Official Hospital Journal of
American Psychiatric Association

# Mental Hospitals

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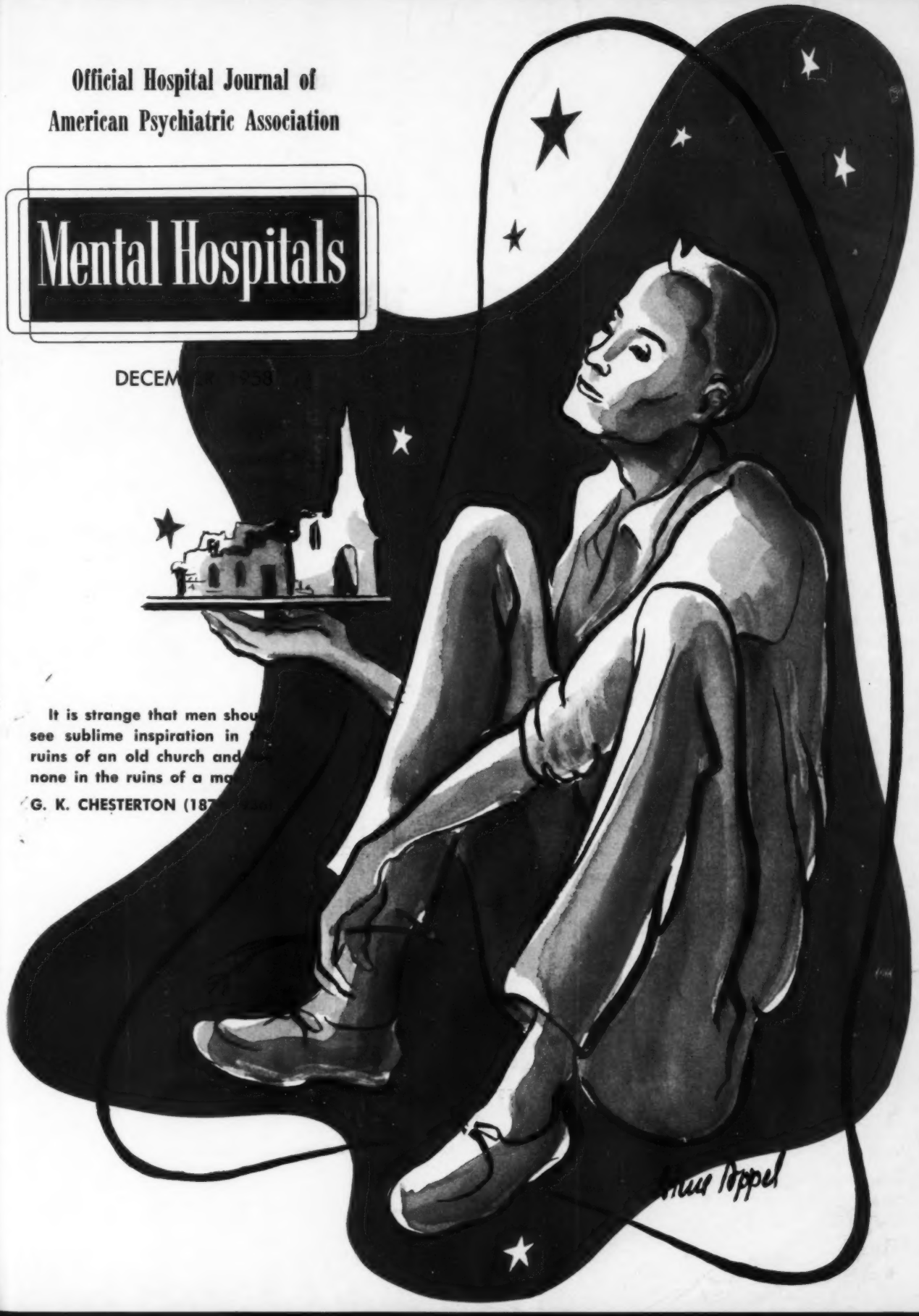

It is strange that men shou
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G. K. CHESTERTON (187

Mental Hospitals

VOLUME 9 NUMBER 10

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Published monthly, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Subscription price: At the rate of $6.50 a year each, up to 44 copies of each issue are included in the dues, which range from $50 to $350 a year for institutional subscribers, based on the number of beds in an institution. Individual subscription rate (for staff members of subscribing institutions only) $6.50 a year. Limited Service subscriptions of $25 a year for related professional organizations and mental hygiene societies include 5 copies of each issue. Published by the American Psychiatric Association Mental Hospital Service, 1700 18th Street, N.W., Washington, D.C. Entered as Second Class mail matter August 1st, 1952, at the Post Office, Washington, D.C. under act of March 3, 1879.

OFFICIAL HOSPITAL JOURNAL OF
AMERICAN PSYCHIATRIC ASSOCIATION

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## CONTENTS, DECEMBER 1958

# *Compazine** for better management of mentally defective children

'Compazine' has greatly facilitated the treatment of institutionalized, mentally defective patients who are emotionally disturbed:

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# A Service-Centered Plan for a Therapeutic Community*

By MAGNO J. ORTEGA, M.D.

Chief of Service, Central State Griffin Memorial Hospital,

Norman, Oklahoma

"CONTINUED TREATMENT" services are usually so large and unwieldy that organized treatment programs are a rarity. In a larger sense, this is true of most state hospitals. At the 1958 A.P.A. Annual Meeting in San Francisco there was a lot of clamor to split up our large state hospitals into much smaller treatment units. The main objection raised was the enormous expense involved, not only initially but in maintaining widely scattered establishments, especially with the current shortage of knowledgeable maintenance personnel.

There was also the perennial complaint about unavailable professional help. Time and again, when we talk of treatment for the mentally ill, we talk mostly of the inadequate staff and the disproportionately great number of patients in need of their services. This relegation of the bulk of our patients to the passive status of recipients rather than allowing them to be participants in an active treatment experience is self-defeating, maybe even unconsciously hostile. A treatment program should certainly be set up only by trained personnel, but its momentum is appreciably increased when patients are allowed to contribute more aggressively to the treatment process.

Our experience last year in Continued Treatment Service C might be useful in studying further ways and means of resolving these problems without incurring unbearable expense. Our guiding administrative principle was that up to a point a hospital can be divided, and the more or less autonomous divisions further subdivided, each subdivision being largely one physician's treatment responsibility. The hospital itself, of course, continues to function as a single entity so far as maintenance and business problems are concerned.

What follows is a brief account of the specific measures undertaken and the changes that took place in Service C during the nine months from July 1957 to April 1958.

### Entire Medical Staff Replaced

Service C is a seven-hundred bed unit for female patients. Until July 1957, when the service acquired three new doctors to replace its entire medical staff, it was what is commonly known as a "continued treatment service." This wholesale change in the medical staff made it possible to institute a totally different approach in the treatment of the chronically ill patients in the service.

There should, we decided, be but one standard of treatment on Service C—the best known to medicine. The service, when we arrived, was well organized, but lacked direction. Enthusiasm was needed too, because to move a sizable mass of people, you must have enthusiastic movers. We all had an abundance of this quality, and my two residents, being young, were not hamstrung by tradition.

Though our treatment approach was by no means unique, we called it, for the sake of distinguishing it, "biosocial psychiatry." It has always seemed to me that what ails chronic patients is not schizophrenia, but rather a state of apathy resulting from chronic neglect and lack of expectations. It is unfortunate that Bleuler, in his famous book on schizophrenia, devoted only a few lines to this outstanding symptom of chronicity. This apathetic resignation, when blanketing chronic patients on a continued treatment service, has to be countered by strong stimulation and mass movement before we can even begin to grapple with the schizophrenic process which lies beyond reach, deep inside this defensive shell.

### Patient Transfers Discouraged

The service, as we reorganized it, consists of three sections, each containing three wards. Each doctor is assigned to one section and transferring a patient from one doctor to another is discouraged. Even inter-ward transfers under the same doctor are frowned upon. In his own section the doctor has three seclusion rooms on one of his wards, which he can use for any of his patients when they need such care. No out-of-service transfer to the maximum security wards of the hospital is made at any time, on the grounds that if a patient becomes disturbed, transfer may make him feel exiled just because he is sicker. Even those who become acutely physically ill are not sent out to the medical service. We provide for them within the service, where the continuity of their psychiatric treatment will not be interrupted.

One ward was set up as our medical and neurological unit in an attempt to avoid using the entire service like a general hospital—that is to say, as an organization run by doctors in the interests of their own clinical, technical efficiency.

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* *Based on a paper delivered at Superintendents' Meeting, Norman, Okla., May 9, 1958.*

We found two pitifully untidy wards and assigned each to a different doctor. Two different approaches are used in managing these wards. One doctor introduces better patients from his other wards so that their example can influence those who are in fairly good contact outside of their incontinence. Since incontinence may be an expression of negative identification with the custodians, we prefer this method to direct precept from the staff. On the other ward, the patient population was not altered, but the staff was, and staff-initiated activity was pushed. (It is well worth remembering that the "total push" program as formulated by Myerson was intended for chronic regressed patients, and not for acute schizophrenics.)

On one of the "untidy" wards, we asked that patients be locked out of the dayroom at least once a week during our rounds, so that we could evaluate them against a different background. This request met with resistance, for, heretofore, the patients had been locked in the dayroom to keep them from soiling their sleeping quarters. The writer had to play tennis twice a day throughout last summer to get rid of his frustrations from beating down passive resistance!

### Section Chiefs Promote Liaison

Now, a word about section chiefs. The creation of these positions has been of crucial importance to Service C. Each doctor is assigned one or more section chiefs from among the psychiatric nurses and nurse technicians. These section chiefs are each assigned two or more wards, for which they are responsible. They improve the liaison between the wards and the doctors, and between the attendants and the nursing office. They also represent and act as spokesmen for their respective sections at administrative service meetings. At these meetings, a healthy rivalry between sections is easily detected, which has, so far, been very productive, and therefore not discouraged. More important, section chiefs serve as the right hand, eyes, and ears of the doctor, and sometimes as his conscience. This single factor in the service set-up accounts for the clinical efficiency which exists despite gross understaffing.

In much the same way that the superintendent had said to me on my appointment as Chief of Service, "Run your service as a hospital within a hospital," so did I tell my section physicians and their section chiefs, "Run your own section as if it were your own business." I have limited my supervision to guiding or to sorting out what may have gone wrong or what is going wrong, rather than attempting to outline specific steps to be taken to solve the presenting problem.

There is a palpable community feeling of mutual respect, essential trust and effective cooperation. This is fortunate, for nowhere can one wheel, no matter how big, carry the whole load. Working conditions such as these enable us to implement and strengthen individual efforts, experience healthy satisfactions, and prevent or correct early tendencies towards strife or tension; and to avert the three big headaches of any administration: work haphazardness, low morale, and rapid turnover.

While a maximum of horizontal competition is encouraged between the sections, vertical competition in the team is kept at a minimum. To keep it this way, I even disqualified myself from grooming my Assistant Nurse Supervisor for the service supervisor's job, and left the job entirely in the hands of the departing nurse supervisor. In cases of impending and not yet imminent departure of any key figure, complications between surrogate and departee can, in this way, be reduced. In order to get away with it in this instance, I told both parties that in the Orient, Wife Number One chooses Wife Number Two, and they all live happily ever after!

When I have to arbitrate between two parties, or even arbitrarily make a diagnosis at diagnostic conferences, something is wrong. So-called judgment decisions are, of course, my sole responsibility whenever no scientific precedent can be found. The trial and error method of testing a decision's validity is set in motion by me, or at least with my approval. Because psychiatry is young, more judgment decisions have to be made in this than in any other medical specialty. (The Chief of Service job is really an outsized one except where another dimension of knowledge obtains in the person, a sort of animal faith, or executive intuition—in effect, a sense of organic harmony.)

Major changes in the service are made usually through combined section planning. Spontaneous participation is the rule, and traditional roles seldom hinted at. Only when milieu collapse impends is each person's professional function highlighted, on the strength of the truism "a professional is the man who can do the job even when he doesn't feel like it."

As soon as we had sketched in our organization pattern, active patient participation was invited. Even group psychotherapy got the ax in favor of ward-centered activities, and the members of existing patient groups became charter members of patient government groups. As the program took hold, patients began to take an active pride in the rocking chairs they had painted and in their ward as a whole. Meanwhile the staff began to develop group consciousness at a more rapid pace. This made possible more mass movement of the patients; even in the evenings they are taken outside for courtyard movies, the benches being fetched from all over the hospital grounds after curfew, by committees of patients chosen by the Patient Government groups. The leaders of the groups serve as hostesses, a duty which helps snap them out of their chronic apathy.

### Drugs Are Last Resort

The initial progress, of course, was slow, but we tried to deal with our own impatience ourselves, individually or in staff conferences, rather than falling into the temptation of using E.S.T. or even drugs. Despite our "no-transfer" policy, we do transfer a patient to another ward before resorting to drugs. We are convinced that when patients feel threatened they must, if possible, have an opportunity to retreat physically, instead of being forced into psychological withdrawal. Physical retreat can more easily be reversed than can pharmacologically-induced suppression.

The huge dayrooms, like railroad station waiting rooms, discouraged formation of small groups for mean-

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ingful social interaction. The unidirectional arrangement of seats to face the inevitable television set made it almost as impersonal as a movie theater. We moved the television set into a fairly large cubicle, and emptied the smaller ones for card-playing, reading, sitting, and listening to music. As one patient puts it, "We need a place to get away from the noisy hall when we are sick." With dressers for dividers, we have converted the dayrooms into dormitories. The mirrors, for the most part, were left out in the hallways as a constant reminder to these female patients of the state of their grooming and attire.

The hallway in our admission ward, which there doubled as a dayroom, was emptied of the card table and television set, which were moved into two cubicles. The hall was thus freed for more vigorous recreational activities.

### Activities Shifted From Admission Ward

On the admission ward, the attendants are chosen from among those who can be matter-of-fact, and we discourage them from being actively friendly. If their welcome exceeds their expectations, patients who are chronically threatened with commitment before actual admission might entertain suspicions about what really lies behind the brick curtain. We also shifted most of the activities from this ward, which had the heaviest activity schedule, to the more chronic wards where the need for them is more urgent and clear-cut. We feel that, with acute cases, milieu therapy should properly be merely the exercise of appropriate custodial care; that is, we allow the patients to develop their own self-set pace. Because the ward is where the patients habitually interact, active membership in this social community makes it the logical center of milieu therapy. We cannot adapt the hospital to each individual patient, but we try to give organic structure to the ward as a therapeutic community to which all patients can adapt. We strive for a homelike atmosphere on the ward, yet bear in mind that the hospital should not be altogether homelike. It was, after all, while living in their own homes that the patients got sick. The physical environment should not be too strange in comparison to the patient's past experience or to her current expectations, because she must feel comfortable enough to be accessible to treatment. What must be significantly different is the attitude we take towards her, which should be as opposite as possible to that which characterized her home life. Thus we strive to provide a corrective emotional experience for each patient, albeit without insight into the infantile roots of the presenting problem. For while a hospital milieu can be interpretative, this is an unrealistic aspiration in a state hospital. Only in small well-staffed hospitals, with specially trained people, can accurate assessment of each patient make possible quantitative titration of prescribed attitudes.

### Ward Meetings Provide Common Bond for Patients

Ward meetings with patients provide them with an opportunity of protesting against imperfections of the service. This brings them together in a common bond of sympathy or hostility. If no complaints are forthcoming, the ward attendant or chief of section conducting the meeting speaks of a long-standing problem, or even more bluntly, asks what the patients do not like about the hospital. At the right time the patients are asked what local remedies they can suggest on their ward. At all times, the discussion leaders are prepared to decide whether administrative action is called for or whether the problem under discussion is one to be dealt with and faced by the group. An attempt is made to demonstrate to the patients how much of the frustration or unhappiness is caused by their own individual or group behavior.

Ward personnel, though not actively consulted in making policy decisions, play a central role in treatment. Team meetings between the morning and evening shifts highlight the desirability of consistency in their attitudes towards their patients. Lately we have also been holding meetings with the workshop supervisors and the work therapist, who is also the charge attendant in our workers' dormitory. We have come to consider the industrial shops as an organic part of our service, since this is where these patients spend most of their waking hours. We make ward rounds regularly on the shops.

On the strength of this kind of staff-patient orientation, and ward-centered feeling of belonging, we have been able to open wards and to grant more ground privileges to patients in closed wards. We have been more successful in opening our doors than have any other attempts I have read about in the literature. We have not had to transfer escape risks off a ward, nor increase scheduled and off-ward activities before opening the door. Our elopements have been from among those who have always enjoyed ground privileges and have perhaps already found them too confining.

### Open Doors an Administrative Decision

The opening of the doors, part-time or full-time, on five of our nine wards, does not mean that the patients on these wards go out at any time they wish. Of course, they can if they want to, but this is discouraged by their doctor. Patients can be just as neglected on the grounds as on sparsely staffed wards. Those without outside privileges may, however, ask for permission to go to the common living room of Service C whenever the doors are open and to go to and fro unescorted.

The decision about whether or not to open the doors was not left up to the attendants or the patients. This primary decision was arrived at by the administrative team, and there was unanimous decision as to which wards might be opened. Then at the monthly meeting with the Chief of Service, the secondary steps, i.e. at what times and for how long, were discussed with both patients and ward attendants. The overcrowding and even worse overconcentration are partially relieved by this increased mobility of patients.

If a patient improves enough under this coordinated milieu program, she is staffed for disposition to a nursing home or her own home. To circumvent inertia, even if patients seem to be only half well, we get them out and take care of subsequent problems in their extramural adjustment by means of an "after-care clinic." In special instances, we have the patient return more fre-

quently on a sort of day-hospital basis. For instance, in one case, a patient used to come to the hospital twice a week to work in the beauty shop, and in the afternoons to attend group psychotherapy. We have another one who is now working in the sewing room and who relapses into suicidal depression without hospital treatment. Or it might be that the patient can work in the daytime but cannot get along with her own family, so she spends the night at the hospital. Or again, it may be an alcoholic who is a week-end neurotic. To avert disaster, she is enjoined to return to the hospital on her days off from work. She failed to make the grade the first time she was released, although she was followed up regularly in the after-care clinic.

In this way, we have unofficially started a day-hospital, a night-hospital, and what we might call a week-end-hospital, to meet exceptional needs. The first day-hospital case has been discharged, and the other three are given self-custody passes, so as not to confuse our records. The positive impact of their continuing sojourn on Service C can be judged by the increase in requests for self-custody passes for job-hunting purposes. (Since this was written, a patient who had been in the hospital for years without exercising any initiative on her own behalf landed a job in downtown Norman the same day she set out to get one.) If the initiative is taken, not by the staff, but by the siblings on the ward and enthusiastically practiced and carried out by them, rather than preached or demanded by authority-figures, this may be a partial answer to a common rehabilitation problem—how to remotivate the chronic patient.

I have so far talked of the hospital practice of psychiatry, especially as it applies to chronic mental patients. What ails them is not chronic psychosis, but mostly apathy from continued neglect. A total push program can be incorporated in milieu therapy in the therapeutic community setting, but I am afraid that, when carried to its logical conclusion, there is a contradiction in terms between the phrase "therapeutic community" and the very popular "team approach." I can only reconcile the philosophy of the team approach with my concept of a therapeutic community if I may be permitted to include the patient as a full-fledged member of the team.

### Patients Make Best Adjunctive Therapists

When we talk of a social field, it can be misleading to cite staff-patient ratios if an absolute dichotomy of function and roles is implied. It is not even what a person is by training, but *who* he is and *how* he fits in, that is important. To my mind, the best adjunctive therapists, under adequate supervision, are the patients themselves. And among non-patient adjunctive therapists, the best ones are those who can descend to the patient level of impaired functioning without being condescending.

When we decry the overcrowding of our mental hospitals and the paucity of adequately trained personnel, we overlook the trainable manpower captive on the wards. The turnover would not be significantly greater than in ordinary purposeful employment, although in the process of helping and identifying with the doctor, patients meet otherwise unfilled needs and improve measurably faster. When I was a first year resident, I had a one-man recreational therapy department in the person of a drug addict whom I trusted with keys to go from ward to ward, organizing recreational and social activities.

To test the success of a social organization, Sivadon * lists a set of four criteria:

1) Are doors unlocked without escapism?
2) Are violent reactions exceptional?
3) Is inertia replaced by adaptive activity?
4) Has the length of stay in the hospital become relatively shorter?

To the extent that we have succeeded in answering these questions in the affirmative, to that extent have we succeeded in establishing a therapeutic community.

I think this social approach to the problem of mental illness is the coming thing, and that hope lies in this direction. Gradually, as it is systematized and refined, I believe it will be the therapeutic instrument *par excellence*. The trend in this direction is already well launched in Europe. Resistance will continue to be felt in this country but with time will dissipate so that we should soon have a crop of "sociotherapists" practicing social psychiatry.

### Size of State Hospital No Index of Popularity

The actual size of state hospitals and the ideal size of a therapeutic community are not compatible. In truth, the size of a state hospital, unlike that of a general hospital, cannot be taken as an indication of its popularity and therapeutic reputation, nor does it exert the same attraction for highly qualified staff. Too often, the size of its patient population is probably an index of its ineffectiveness in providing the proper treatment. If it is running smoothly, this is probably to the credit of its excellent administrative staff.

I feel that if a state hospital is to be treatment-oriented, its structure should be service-centered. A service can be tailored variously to achieve therapeutic ends. Unity in the service, rather than uniformity of the services, should be the objective.

The individual services should be actively consulted in drawing up the budget. It seems to me that the only requisite to participation in this should be the relative permanency and remaining tenure of office of the person who will use the money on the basis of past first-hand experience. The closer we get to consumer level in inviting this participation, the closer can our financial outlay be estimated for each outstanding need. This can be time-consuming, but I wager it will be time well spent.

After the budget has been approved by the superintendent and passed by the legislature, each service should be in a position to go ahead with its plans, with full confidence that money budgeted is available for the asking, instead of being hamstrung by uncertainty about its ability to move ahead and how far, to reach the goals it envisions for the whole fiscal year.

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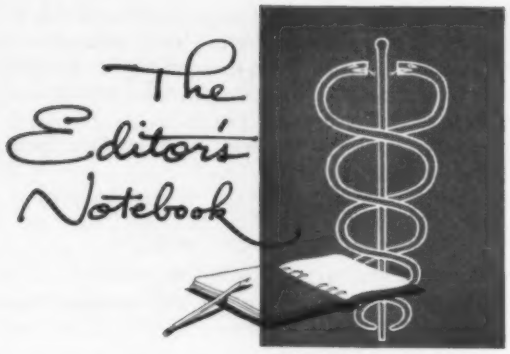
* *Sivadon, P. D., "Techniques of Sociotherapy," Psychiatry, Aug. 1957.*




Suppose you've all had post-mortems about the 10th Mental Hospital Institute by now. We've had ours—we feel proud but also stimulated to make some changes for the 11th Institute to be announced when details are worked out. We are trying to encourage everybody to send us ideas and to get these ideas in the forum for discussion. In our November issue we had a brief summary of some of the highlights of the 10th, but nobody can truly convey the flavor, the enthusiasm, the sense of fellowship and even the fun we all had at this meeting.

One of the exciting developments was the initial meeting of the Commissioners and the formation of an organization through which the views of the Commissioners of the 49 states may be expressed; the organization will be able to work as a body on problems of special significance at the state level on a national basis.

We are continuing our discussion on communication (Osmond and Clancey, Page 15). Many of you doubtless have ideas on this subject, and we would welcome your communication on what seems to be developing into a series on communication. SO COMMUNICATE! . . . We look forward to considerable discussion on the article by Mr. Summers (Page 29) on the use of patient help in the hospital laundry. What are your ideas on the use of patient help in other areas of the mental hospital? . . . Isn't that an unusual program described by Dr. Kraft (Page 41)? You may know of some other interesting experiments where treatment programs are centered about special nosologic categories. And what are the merits and demerits, as you see them, of this kind of orientation? . . . We are grateful to Mr. Klein, one of our Consultants, for his graphic description of his visit to a Russian mental hospital (Page 19). It is encouraging that wherever scientists work we find the same qualities common among them. "Men should be judged, not by the color of their skin, The gods they worship or the vintages they drink, Nor by the way they fight, or love, or sin, But by the quality of thought they think." (Laurence Hope, 1865-1904.)

QUOTES: Captain Norman Lee Barr, our Academic Lecturer, says, "When in trouble, When in doubt, Run in circles, Scream and shout." Dr. George Jackson, Kansas, "The better a state hospital gets, the more one becomes aware that it is only a part of the total program and that community services must be developed. . . ." Dr. Clifton T. Perkins, Maryland, "I have my tongue in my cheek whenever I mention preventive mental health. I don't know how we measure it." Dr. Harold L. McPheeters, Kentucky, "Any patient can expect only 20 minutes a month of any individual professional person's time." Dr. Addison M. Duval, Washington, D.C., "I wonder if we do not have to take a good hard look at our standards, especially with regard to medical records. Maybe we have to give up some of our medical hypocrisy." Dr. Mesrop Tarumianz, Delaware, "I believe the idea of using part-time practitioners in state hospitals can be extended to part-time nurses, social workers, occupational therapists, etc." And Dr. T. again, "We must make psychiatric hospitals identical to general hospitals; we cannot treat and direct the tremendous state hospital situation in any other way. The chronic patient must be treated in nursing homes." Dr. Dale C. Cameron, Minnesota, "Sometimes I think we ought to have a whole month devoted to all our meetings and stay away from our work, and then go back to our work for the rest of the year." . . . Dr. Dean K. Brooks, Oregon, "Definition of claustrophobia —what an Alaskan feels when he finds himself in Texas." Dr. Glen J. Speriando, Indiana, "About one third of the mental hospitals have no registered pharmacist. Only about 5% of graduate pharmacists go into hospital work." Mrs. Helen K. Johnson, Kansas, "The operating economies that can be effected will more than pay the salaries of a housekeeping staff." . . . Dr. William C. Menninger, Kansas, "There is so much unnecessary suffering, fear and heart-ache in the world that could be alleviated if we had the man-power, money and facilities."

NOTES: Did you know that almost one-third of all patients in New York state institutions are admitted voluntarily or on a physician's certificate? Two years ago only 10% were admitted in this way. What is your record? . . . More N.Y. statistics: The N.Y. Department of Mental Hygiene is the largest in the state government; it employs 37,000 persons, more than one-third of all the state employees; it utilizes about one-third of the state's general purpose budget—or about 190 million dollars to care for 120,000 patients in 31 mental institutions. Dr. Joel Elkes, Director of the Research Program at St. Elizabeths Hospital, Washington, D.C., says he is trying to "create an academic unit in a mental hospital, a kind of microscopic microcosm with roots of basic science in clinical situations." This clinical neuropharmacology research center now in the process of development is intended primarily for the study of the mode of action of drugs on mental function in man, with special reference to its bearing on problems of mental disorder. The program is part of a plan for a collaborative research program between the hospital and the National Institute of Mental Health, centered in the hospital and situated on its campus. It is also an expression of the wish of the hospital and the Institute not only to move with the times but to be slightly ahead of them. Clinical research is inseparable from clinical care and in the last analysis, it is the clinical program of the hospital which will reflect whether the research program is useful or otherwise.

Matthew Ross, M.D.

# 'STELAZINE'

## ANTIPSYCHOTIC

### for treatment of chronic and withdrawn schizophrenics

'Stelazine' is the first psychopharmacologic agent to be effective in significant numbers of chronic and withdrawn schizophrenic patients.

Prime candidates for 'Stelazine' therapy are the "back-ward," withdrawn patients for whom drug therapy has been abandoned or perhaps never attempted. Clinical studies have demonstrated that on 'Stelazine' therapy these patients become alert, communicative, sociable and responsive to the therapeutic milieu. Many appear to be beneficially motivated, and for the first time show an interest in leaving the hospital.

It is Stelazine's effectiveness in these patients that has set it apart from other psychopharmacologic agents. Withdrawal should be considered an indication, rather than a contraindication, for 'Stelazine'. Moreover, chronicity and failure to respond to other drugs are good reasons for a clinical trial.

We are convinced that once you have tried 'Stelazine' in your chronic and withdrawn patients you will find that this drug is truly a different and very important addition to your armamentarium.

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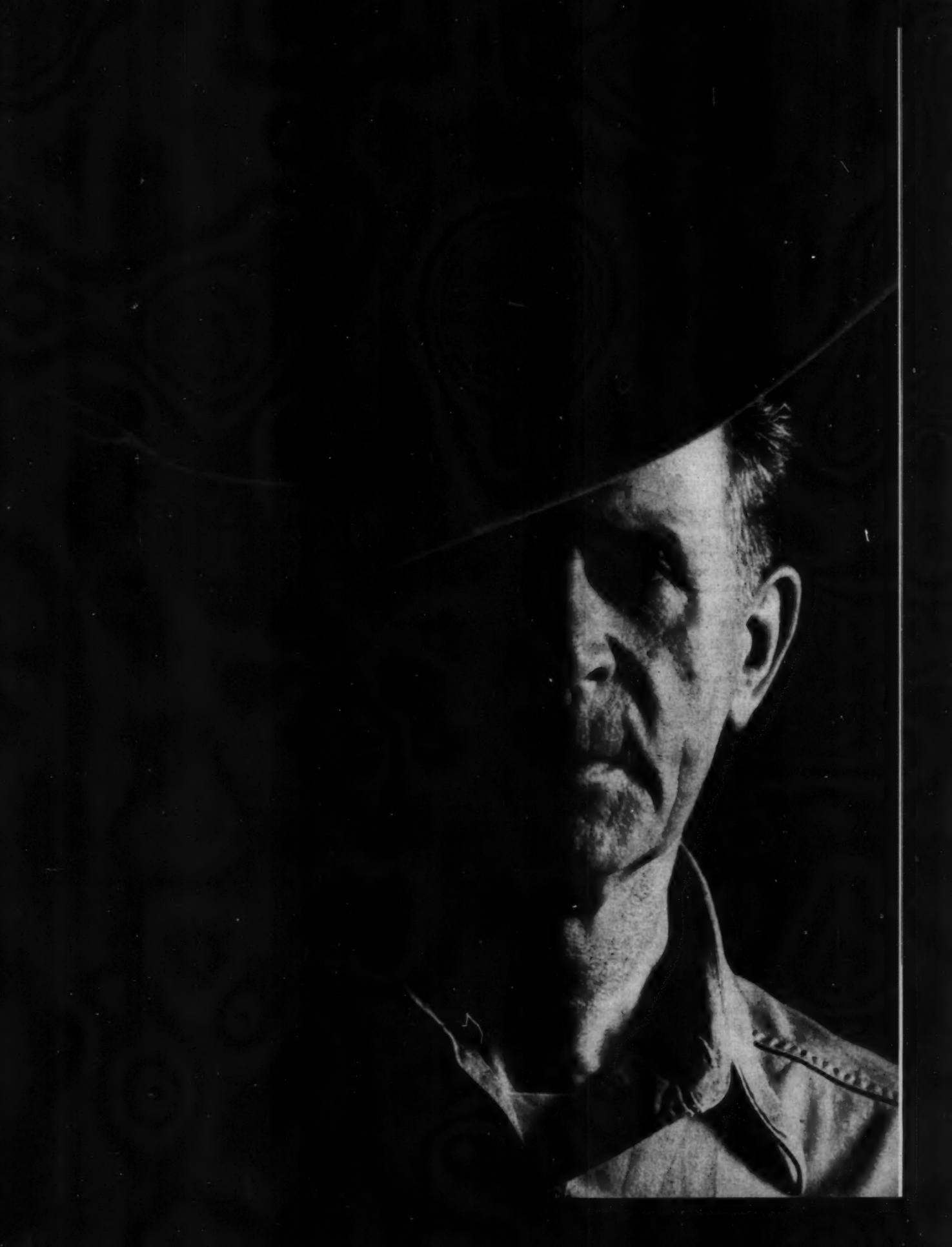


## ADMINISTRATION AND DOSAGE OF 'STELAZINE'

'Stelazine' dosage must be adjusted to the severity of the condition and to the response of the individual. Dosage should be titrated carefully in order to achieve maximum therapeutic effect with the lowest possible dose.

'Stelazine' is intended for use only in patients who are either hospitalized or under adequate supervision. As yet, dosage has not been established for children under 12 years of age.

### *Oral*

The usual starting dose is 2 mg. t.i.d., but many patients can be started satisfactorily on 5 mg. b.i.d. (Small or emaciated patients should always be started on the lower dosage.)

The majority of patients will show optimum response on 5 mg. t.i.d. or 10 mg. b.i.d., although a few may require 30 mg. a day or more. Optimum therapeutic dosage levels should be reached within 2 or 3 weeks after the start of therapy.

When maximum therapeutic response is achieved, dosage may be reduced to a satisfactory maintenance level. Because 'Stelazine' is inherently long-acting, maintenance doses can be administered b.i.d.

### *Intramuscular (for rapid control within hours)*

The usual dose is 1 mg. to 2 mg. (½ cc.–1 cc.) by deep intramuscular injection every 4 to 6 hours, as needed. More than 6 mg. within 24 hours is rarely necessary. As soon as a satisfactory response is observed, oral medication should be substituted at the same dosage level or slightly higher. If motor restlessness or jitteriness occurs, the dosage should *not* be increased. See "Side Effects" below.

Only in very exceptional cases should dosage of 'Stelazine' Injection exceed 10 mg. within a 24-hour period. Since 'Stelazine' has a relatively long duration of action, *injections should not be made at intervals of less than 4 hours* because of the possibility of an excessive cumulative effect.

'Stelazine' Injection has been exceptionally well tolerated; pain and induration at the site of injection have not been reported.

## SIDE EFFECTS

Clinical experience has shown that when side effects occur, their appearance is usually restricted to the first 2 or 3 weeks of therapy. After this initial period, they appear infrequently even in the course of prolonged therapy. Termination of 'Stelazine' therapy because of side effects is rarely necessary.

### *Extrapyramidal symptoms*

Extrapyramidal symptoms are seen in a significant number of patients given 'Stelazine'. These symptoms may resemble Parkinsonism or be of the dystonic type. The muscles of the face and shoulder girdle may be selectively involved. Symptoms observed have included: spasm of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, oculogyric crisis, trismus and swallowing difficulty. Occasionally, there may be elements of excitement and increased suggestibility.

Despite some similarity to symptoms of serious neurologic disorders, these extrapyramidal symptoms are reversible. They subside gradually—usually within 24 to 48 hours—when dosage is lowered or the drug temporarily discontinued. If desired, they may be more promptly controlled by the concomitant administration of anti-Parkinsonism agents. Severe dystonia has responded rapidly to intravenous caffeine sodium benzoate.

### *Akathisia (motor restlessness and turbulence)*

Some patients may experience an initial transient period of stimulation or jitteriness, chiefly characterized by motor restlessness and sometimes insomnia. These patients should be reassured that this effect is temporary and will disappear spontaneously. If this turbulent phase becomes too troublesome, reduction of dosage or the concomitant administration of small doses of phenobarbital or some other mild sedative may be helpful.

At times, this effect may be strikingly similar to the original anxiety manifestations of the psychosis. Thus, it is important to identify these symptoms as a side effect, and to see to it that the dosage of 'Stelazine' is *not* increased until these symptoms have disappeared.

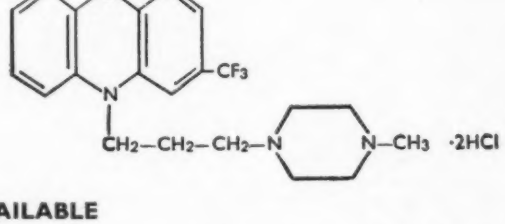
### *Others*

Other side effects have been minor. Drowsiness has occurred but has been transient, usually disappearing in a day or two. There have been occasional cases of dizziness, muscular weakness, anorexia, rash, lactation and blurred vision.

'Stelazine' is contraindicated in comatose states. For further information, see the S.K.F. literature.

## CHEMISTRY

'Stelazine' is 10-[3-(1-methyl-4-piperazinyl)-propyl]-2-trifluoromethylphenothiazine dihydrochloride.




## AVAILABLE

'Stelazine' Tablets: 2 mg., 5 mg. and 10 mg., in bottles of 50 and Special Hospital Packages* of 1500.

'Stelazine' Injection: 10 cc. Multiple dose vials (2 mg./cc.), in boxes of 1 and Special Hospital Packages* of 20.

*Available only to non-profit and government hospitals.

**REFERENCES** 1. Feldman, P.E.: An Evaluation of Trifluoperazine in Chronic Schizophrenia, in Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, pp. 87-97. 2. Goldman, D.: Clinical Experience with Trifluoperazine: Treatment of Psychotic States, *ibid.*, pp. 71-86. 3. Markey, H.: Patients with Chronic Schizophrenic Reactions Treated with Trifluoperazine, *ibid.*, pp. 150-155. 4. Kovitz, B.: Management of Psychotic Tension Symptoms with Trifluoperazine: A Preliminary Report, *ibid.*, pp. 144-149. 5. Brooks, G.W.: Definitive Ataractic Therapy in the Rehabilitation of Chronic Schizophrenic Patients: A Preliminary Report on the Use of Trifluoperazine, *ibid.*, pp. 54-61. 6. Rudy, L.H.; Rinaldi, F.; Costa, E.; Himwich, H.E.; Tuteur, W., and Glotzer, J.: The Use of Trifluoperazine in the Treatment of Acute and Chronic Psychotic Patients, *ibid.*, pp. 125-137. 7. Freyhan, F.A.: Occurrence and Management of Extrapyramidal Syndromes in Psychiatric Treatment with Trifluoperazine, *ibid.*, pp. 195-205. 8. Kinross-Wright, V.J.: Trifluoperazine and Schizophrenia, *ibid.*, pp. 62-70. 9. Gunn, D.R.: The Role of Trifluoperazine in the Treatment of Refractory Mental Patients, *ibid.*, pp. 47-53.

# COMMUNICATION—AN EXPRESSION OF ADMINISTRATION

By HUMPHRY OSMOND, M.D. Superintendent
and I. L. W. CLANCEY, M.D. Clinical Director
Saskatchewan Hospital, Weyburn, Canada

IN THE September issue of MENTAL HOSPITALS, Messrs. Dolgoff and Sheffel, in their article "Communication—the Pulse of the Mental Hospital" illustrate the dangers which the shoemaker faces when he does not stick to his last. Since they are administrators, one might reasonably expect their paper on communication to deal with administrative issues, but these played a regrettably small part in it.

We agree with them that "a primary and continuing task of the hospital administrator is the diagnostic appraisal of his organization's communication system," but we do not agree with their implication that the therapist-patient relationship is a useful model from which to develop, appraise and maintain a communication system which is largely an expression of the relationships existing in an enterprise. These relationships are and must be defined by the formal organization.

The doctor, whether a physician, surgeon, obstetrician or psychiatrist, who approaches his colleagues—or for that matter, anyone else—as if they were his patients, perpetrates a breach of manners and is intruding where he has no right to be. Should one assume that the relationships which a doctor develops with his patients are identical with those which he has with his colleagues?

It is not enough, however, to question the authors' assumptions. We are obliged to suggest some other ways of dealing with the problems which they present. The theory of organization on which we shall base our discussion here may be unfamiliar to some administrators and to many psychiatrists. It is the methectic* theory of Professor T. T. Paterson, of the University of Glasgow, Scotland. This theory involves definitions of authority and therefore the types of relationships which can exist.

Organization is the function of ordering and coordinating such other functions as are necessary for the attainment of the goals of an enterprise. It will employ as one of its operations the defining of relationships between the persons fulfilling those functions. According to Paterson, "All forms of human relationships involve authority and this authority is one or more of five forms, depending on the purposes of the group and its structuring of functions to achieve the goal of the group." Authority is the entitlement to do something by reason of certain attributes or combination of attributes.

For our immediate purpose we can confine ourselves to two types of authority.

(1) *Structural authority.* This is the entitlement stemming from legal or other contract vested in a position in the enterprise and so in the person carrying that position, to order and coordinate functions pertaining to other positions, and to expect and/or obligate obedience in ordering and coordinating.

(2) *Sapiential authority.* This is the entitlement to be heard by reason of knowledge or expertness.

Of what then does communication consist? It is sending and receiving signals which allow people to tell others what they are thinking, feeling and perceiving, and further, what they are doing and what they intend to do. The result of this capacity to signal is that people can join in enterprises together. Without signaling, or if signaling becomes impaired, chaos follows.

There are many ways of signaling, but human beings have language, a flexible instrument capable of great refinement, by which misunderstanding can be avoided. The advantage of depending on language for communication is that, when used well, it is clear, comprehensible and avoids ambiguity or uncertainty. One must first insure that what can be made explicit and straightforward is made explicit and straightforward. In a large organization like a mental hospital, composed of diverse people who differ in age, sex, occupation, social and cultural background and interests, it is unwise to devote one's energies to subtleties. An administrator is asking for trouble if, before he has insured that orders, advice and information pass freely and correctly through the organization, he uses up energy in decoding nods, becks, winks and hints. No large enterprise has ever survived long without a system of formal communication based as it must be on a formal organization.

What then is the formal system of communication? It consists of orders, advice and information flowing through the organization. It is only by knowing his position in the structure and the function of that position and its relatedness to other functions and positions, that any person can recognize the communications he can expect to receive and those which he is obliged to give.

What then are orders? An order is that communication proper to the type of authority which Paterson calls structural. An order imposes an obligation; one is bound to obey it. Failure to obey it results in punishment. When an order has been received, it must be acknowledged; it may be questioned, either to obtain clarification or to raise objections, but when the giver of the order insists, the order must be obeyed and its results reported. In recent years, because of the bandying about of such words as "authoritarianism," many administrators have become squeamish about giving orders. Yet when they fail to do so, they disturb their subordinates because an order implies not only *direction* but *protection*;

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* *Methektikos—participation (Aristotle); see Paterson, T. T., Morale in War and Work, Max Parrish, London, 1955.*

unfortunately, few recognize this protective aspect of giving orders. The protective aspect of an order is this: whoever gives the order becomes, in a large degree, responsible for its consequences. Subordinates who do not receive orders at the appropriate time become dissatisfied and insecure because they quite rightly resent the failure in responsibility (abdication) of those who have the duty of commanding. This resentment is not reduced even when it can be rationalized by psychodynamic formulations. Orders are very important; no organization can survive without them—but no organization will survive on orders alone. Advice, too, is needed.

### Advisers Have Specialized Knowledge

Advice is the communication appropriate to the sort of authority called sapiential. An adviser helps and protects by virtue of his specialized knowledge. In a hospital, an adviser may be appointed by the administrator, either for his own benefit or to give advice to his subordinates so that they can better fulfill their functions. While one has no choice between obeying an order or leaving the organization (apart from appealing through one's superior to a higher authority) one may choose whether or not to take advice. If, however, one fails to take advice from someone appointed to give it, one must also accept the responsibility for failure. Failure to take advice from a competent adviser may result in failure to reach one's objective, and for this one may very well be punished by those having structural authority. The reciprocal action from the advised to the adviser is to exchange information which may or may not modify the advice given.

It is worth noting here that these two sorts of authority —structural and sapiential—are not necessarily exclusive. People can, and very often do, possess both types of authority. A familiar example is the medical superintendent who possesses sapiential authority by virtue of his medical qualifications—his structural authority stemming from his position as superintendent.

Information, the third kind of communication, carries with it no obligation or expectation. It is subject to comment and discussion. The criterion which must be applied to it is whether or not it is useful and relevant in helping those who receive it to perform their function. Everyone in an organization is obliged to provide others with the necessary information for them to fulfill their various functions. While information must flow upwards and downwards and laterally, it is essential that irrelevant information should be eliminated because it causes confusion. It is one of an administrator's most important tasks to see that appropriate information reaches the appropriate group of people in the right amount at the right time. Irrelevant information is "noise" and clogs communication.

Bearing in mind these various forms which communication takes, let us examine some of the examples which Messrs. Dolgoff and Sheffel use to illustrate their article.

"The chief nurse has asked the business manager for new rugs for the patients' lounge. She has received no reply for two months. The business manager has communicated to her without saying a word."

In this case, the business manager has failed to fulfill his function, part of which is to communicate properly and has thus perpetrated an administrative error. But the blame here lies upon the person to whom both the business manager and the chief nurse are responsible—the administrator himself. The authors imply that better communication will result in better administration, but neglect to observe that the definition of formal relationships, part of the function of the administrator, is the first step to enhancing and maintaining communication. If the administrator has not defined the formal relationships, no amount of communication will remedy his neglect.

"The manager (of a VA hospital) makes a plea for more 'efficiency in the hospital.' This may be viewed by the ward doctors as an order to discharge more patients, by the supply officers as an order to reduce the consumption of paper cups, and by the secretaries as an order to turn off the lights."

This medical superintendent has mistaken his role, which is not one of pleading, but of superintending and advising in medical matters, i.e., his authority is both structural and sapiential. If he has changed his role to one of pleader, then one must expect confusion. An administrator can neither demand or even plead for an abstract "increase in efficiency." His role is that of a giver of orders and a coordinator of other people's functions, and it is is his duty to state where the organization is failing to reach its goals. Once he has done this it is possible for him to require those who are directly responsible to him, and only those directly responsible to him, to fulfill their functions. Otherwise, he usurps their authority and denies their responsibility. Here again we have no evidence of any failure in communication, but we do have a gross administrative error. This manager failed to fulfill his function by substituting pleading for directions; by apparently communicating with those who were not directly responsible to him, he caused predictable confusion.

### Other Examples Questioned

"A doctor asks an aide where he was ten minutes ago. The aide replies that he was at the canteen. The doctor says nothing more, but the aide feels he has been criticized for leaving the ward. He feels the doctor does not appreciate the unusual amount of stress he has been under that day in working with the patients. Actually the doctor was just trying to be friendly and did not intend any criticism."

The authors interpret this as being a misunderstanding due to poor interpersonal relationships. In our opinion it is a vivid illustration of the misfortunes which attend organizations which pay no attention to formal relationships. Neither aide nor doctor in this illustration understood their relationship. The aide behaved as though the doctor had structural authority, and the doctor as though a personal relationship existed between him and the aide. Clear communication can only occur when relationships have been defined and mutually accepted. It is significant that this excerpt gives one no clue as to what relationship does exist between the doctors and aides in this hospital—but whatever it is, this aide and this doctor did not understand it.

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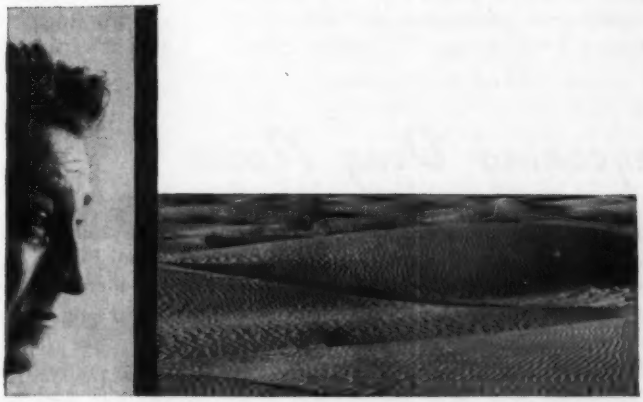

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*References*
1. Braun, M.: Am. J. Psychiat. *113*:838 (March) 1957. 2. Feldman, P. E.: Am. J. Psychiat. *114*:143 (Aug.) 1957. 3. Hutchinson, J. T.: Paper presented, American Psychiatric Association, Philadelphia, Pa., November 16, 1956.

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"A superintendent and his department heads after considerable study and experimentation decided to adopt a new procedure for referring patients to occupational therapy. At the meeting where this decision was made, there was a lengthy discussion regarding the purpose of the change in timing and the effect that this change might have upon the personnel of the various departments as well as upon the patients. The superintendent knew that unless this plan was thoroughly understood by the department director, there was likely to be considerable confusion. When it was introduced, because it involved drastic changes in procedures followed by physicians, nurses and aides, the superintendent assumed that the department heads would follow his example and provide their staffs with similarly detailed explanations. Therefore one can imagine his surprise when he heard about the complaints and confusions which he tried so hard to avoid through meeting with the department heads. He had not trained his carriers."

Once again an administrative failure masquerades as a problem in communication. This medical superintendent had not recognized that heads of departments require both professional and administrative competence. By launching what was apparently a complicated plan before discovering whether his subordinates had the administrative ability to put it into effect, the superintendent courted the failure which ensued. Before appointing a department head the superintendent should have recognized that professional competence cannot compensate for administrative ineptitude.

Stanton and Schwartz noted in a slightly different context that psychotherapeutic and administrative roles should not be confused. These authors seem to sense that confusing these two will result in trouble; they advise the administrator to time his moves as carefully as "a trapeze artist," adding "even when all this has been done many of his communication problems will remain unsolved, for full communication between human beings is as rare as it is gratifying." While we do not doubt that personal relationships can have either a beneficial or malignant effect on communication, the superintendent who depends on them to solve administrative problems will indeed have to move with the circumspection of a trapeze artist. At best he will develop an organization which depends upon his personality and so will be unduly vulnerable in his absence. It is only when organizational relationships are understood that it becomes possible to consider the effects of personal peculiarities. There is a need for a system of communication deriving from a clearly defined formal structure appropriate to the goals and purposes of the particular enterprise. The administrator must recognize that his task is the unromantic one of influencing people without necessarily winning friends, and if he succeeds in carrying out his function, it is not impossible that some of the glad rewards of the informal system will come his way.

# The Burgeoning Drug Room

By DR. WHATSISNAME

Like a latter-day phoenix, the drug room has risen from a basement hideaway to a position of importance in the mental hospital. When the old now among us were much younger, the hospital pharmacy was a warehouse for such colorful items as cardamon or elixir of iron, quinine and strychnine. Most physicians then were veritable therapeutic nihilists and used the drug room principally as a source for staples like aspirin tablets, laxatives, and "tonics", and for mysterious alembics known as alteratives, in which no one quite believed. Relatives expected the sick to be given medicine, so the drug room dutifully dispensed gentian, and ichthyol, Blaud Pills and Brown Mixture. But it was not seriously considered an important cog in the hospital machine.


But from their magic vats, the pharmaceutical chemists have now distilled a brew of potent drugs. Antibiotics and tranquilizers, analeptics and steroids, slow-release capsules and fast-acting tablets—daily they come. The drug budget has catapulted, and woe betide the doctor who has not kept up with the popular magazines in their reporting of new medications! From a minor, peripheral official, the hospital pharmacist has become a V.I.P. He holds the key to the magic door. Fleet-footed messengers now line up at his counter to seize the encapsulated beatitudes available there—a vast change from the days when the hospital pharmacist was delighted to have an off-duty attendant to talk to. Hospitals form drug committees with the pharmacist in the central position. The printing of formularies has now become hospital big business. The hospital prescription blank, once used for inter-office memos and informal bridge scores, is now a passport to health and tranquility. The wheel has turned full cycle. A century ago it was felt that medicines were the proper business of Medicine. And having passed through eras of moral treatment, physiotherapy, focal infection, dietetics, psychotherapy, and electronic technics, we have made the full turn and are back in the drug room. Not unquestioningly, perhaps, but at least every drug will have its day!

# A Visit To KASHENKO MENTAL HOSPITAL, MOSCOW

By ROBERT H. KLEIN, Chicago, Ill.

*(This article is based almost exclusively on information given to me at the time of my visit by Mr. Tigran Bogdasarov, Chief of Administration, Kashenko Mental Hospital. Because of the hazards of speaking through an interpreter, the report has obvious limitations. Some of the figures used are approximations. I was unable to check the data with other sources, because of my relatively short visit. R.H.K.)*

Administratively, R. R. Kashenko Mental Hospital is responsible to the Moscow City Department for the Protection of Health, which is in turn responsible to the Executive Committee of the Workers' Deputies of the city. Dr. Alex L. Andreev, a psychiatrist, is the director of the hospital, but was absent on the day of my visit, a Sunday.

The hospital, which was established under the Czarist regime more than forty years ago, is located within the city of Moscow. It has 2,220 beds, including 240 for children. It also has a 180-bed branch hospital just outside the city limits. This branch, which I did not visit, operates a small farm which has a herd of dairy cattle. I was told that patients are transferred to the branch only upon their own request. I also understand that all mental hospital patients in Russia are "voluntary" with the exception of psychotics accused of a crime, who are committed to a hospital by the court on the advice of three psychiatrists.

### Medical Care Free to Citizens

All medical care within the Soviet Union is provided without charge to its citizens. Patients are said to be paid full wages during illness and confinement. If illness, including psychiatric illness, is judged to be permanent, the wages cease and the individual receives a pension.

The population of Moscow is about five million. For medical purposes the city is divided into twenty districts. Kashenko Hospital and its branch, with their combined total of 2,500 beds, serve thirteen districts. The other seven districts are served by seven smaller mental hospitals with a total bed capacity of about 3,000. Thus there is a little over one psychiatric bed for each thousand of the general population of the city.

Each of the medical districts is served by at least one general purpose dispensary, which includes a neuropsychiatric section. In addition, there are a number of psychiatric clinics to which the general purpose clinics may refer patients. Either type of clinic may refer patients to the mental hospitals. Each dispensary and clinic has a central office and reception center which keeps current information on the census and patient movement of the mental hospitals. Thus new patients can be moved into the hospitals immediately when beds are available. There was no indication of a waiting list.

### Inpatient and Day Care for Children and Adults

The psychiatric clinics and N.P. sections of the general dispensaries are organized into an adult psychiatric section, a children's section and inpatient and day care services. The adult and child sections do diagnostic studies and provide outpatient therapy. The clinics act as facilities between the dispensary and the mental hospital. The inpatient services may have from 50 to 75 beds for the acutely ill. Typically, patients are not held there for more than a month. Because of its ability to provide prompt and active treatment for acutely ill psychotics, this service is said to eliminate, in many instances, the necessity for long hospitalization. The day service, in addition to normal activities, helps to bridge the gap for patients ready for discharge from the mental hospital, but who may still have difficulty in adjusting to full community life.

The Kashenko Hospital census generally runs at or near capacity. Discharges vary from ten to forty each day and the total annual admissions are about 9,000. Most of these—8,500—are actually re-admissions, with 500 or less being first admissions. The policy is to give intensive treatment and return the patient home as quickly as possible—even if he has to come back at a later date. Prior to discharge, a commission of three doctors in the hospital determines the extent of the patient's improvement, and states what limitations, if any, should be placed upon his activity and type of employment. Conditional discharges and trial visits as we know them in this country are not used. There are, however, infrequent releases for brief periods to permit a patient to spend a holiday or other special occasion with his family or friends.

A small number of patients are transferred, before discharge, to a sort of "half-way house" on the hospital grounds. These "half-way houses" have much less "hos-

pital" atmosphere than the parent institution. The patients are given more freedom. They wear normal clothing and there are no locked rooms. Facilities include a library, game room, a comfortably furnished "living room" with radio and television, as well as a small drug room and offices for nurses and doctors. Patients receive the same types of treatment as in the hospital itself, but the proportion of staff to patients is higher in this hundred-bed facility. Perhaps 5% of these patients are subsequently returned to the hospital; the rest, after a few weeks, are discharged to their homes.

On discharge, patients are requested to report to their district dispensaries or dispensaries connected with their factory or farm for follow-up care. If a patient does not so report, the dispensary staff locates him in his home, arranges follow-up treatment if necessary and/or assists the family to adjust to his needs. The follow-up care is based on a continual flow of hospital discharge information to the central clinic office and thence to the individual clinics. If hospitalization is again indicated readmission may be arranged by the dispensary or clinic.

The hospital population consists of rather more women than men. Children from about seven to sixteen years old are admitted to special wards; however, if a teenager is physically well-developed, he may be placed in an adult ward. The hospital does not take the mentally retarded. Apparently there are some small institutions for these patients, but I believe that a larger proportion of mentally retarded people live with the general population than do so in the United States. Neither are there any senile patients in the hospital. Such individuals are cared for in other types of institution. Only about half a dozen alcoholics were in Kashenko at the time of my visit, and this in spite of the fact that many clinics and hospitals for the treatment of these patients have recently been closed. (Although the price of vodka has been raised again, I saw a considerable number of drunks on the streets of Moscow.)

### No Central Admission Building

Kashenko does not have a central admission building. Patients go straight to nursing units that have vacant beds. No sleeping rooms are large—from two to twelve beds is the usual size—and most are unlocked, although there are some locked rooms. There may be eight or ten such small dormitories off the corridor of each nursing unit of 50 to 60 patients.

I observed no detention screens, and found that instead double-glass windows are used. This is because of the cold winters, and the outside pane is made of an extremely resistant glass. To prove its strength, my escort threw a large rock at one window with considerable force. It didn't break or even splinter!

All patients, except those in the "half-way house" wear pajamas rather than street clothes. However, the Russian pajama differs considerably from the American garment of the same name. It is typically a vari-colored striped garment of heavy material, and is considered to be an excellent lounging garment, especially in resort areas and in the south of Russia. Thus there is apparently no stigma attatched to the use of this garment in a mental hospital. It is not particularly elegant, but most of the Russians I saw in the community were poorly dressed by American standards and women's hair styling was unattractive. Thus, when the Russian mental hospital patients' appearance is compared to that of people outside the hospital, the patients, despite their situation, are probably neater and cleaner. As is typical elsewhere in mental hospitals, the patients are not permitted to possess razors, knives or matches.

The treatments available include insulin therapy, electroshock, although the use of this is decreasing, and the well-known Russian sleep therapy. For the last four or five years, Russian psychiatrists have been using tranquilizing drugs similar to those used in this country, and their use in Kashenko was very, very extensive. There is a belief that certain kinds of mental illness respond to dietary changes, and some patients, therefore, have special diets and also receive large doses of vitamins.

Occupational and recreational therapies are extensively used, and the facilities provided are fairly typical of those seen in hospitals in this country. Kashenko patients however, do very little ward housekeeping and never help in food preparation, food service or the hospital laundry. My hosts were shocked to learn that patients perform such services in many American hospitals.

### Toilet and Sleeping Facilities Adequate

On the ward, typical iron hospital cots are used. There seemed to be adequate linen and bed clothing, which were clean and in good order. Most, but not all of the patients were provided with individual cabinets for storing personal possessions. Toilets and bathrooms were adequate and relatively well-equipped and compared favorably with those in the better Moscow hotels.

Each nursing unit has its own special dining room and service kitchen, to which food is brought from a central kitchen. Only minor food preparation is done in the nursing unit kitchens. Dishes and silverware are washed and kept there. Most of the dining rooms I saw were attractively furnished, with curtains at the windows, and tables for four set up with clean tablecloths.

All kitchen windows were screened and many fly strips were noticed. (I didn't see screens elsewhere in the hospital, but flies don't seem to be a serious problem.) Kitchen equipment was of various ages, including some new, modern pieces. There were ample cold storage walk-ins, one of which was filled with beef carcasses. Another contained cans of fresh milk, and yet another was filled with butter and fresh fruit, some of which had been produced by the branch hospital farm. Most food, however, is purchased.

Four meals are served daily, breakfast about eight, dinner at noon, milk and cookies at four and supper at six. There are two complete kitchen crews, each of which works on alternate days for twelve hours and then has a day off. The hospital diet apparently includes larger quantities of meat, milk, vegetables and fruit than the typical Moscovite eats. (Most Moscow citizens seem to be amply fed. Many are somewhat obese, but the general diet includes more bread and potatoes than we are accustomed to in this country.)

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Of these, 167 are doctors, 105 of whom are psychiatrists. The table of organization calls for one psychiatrist to every 25 patients. From 70% to 75% of the doctors in this hospital are women—roughly proportionate to the number of women in the medical profession throughout the Soviet Union. The hospital staff includes 640 "medical assistants," who might be compared with our registered nurses and other professional ancillary workers. They must have completed the tenth grade—equivalent to our High School graduation—and then have had three to four years of specialized medical education. These medical assistants include not only people who perform nursing functions, but also various technicians specially trained for work in the laboratories, X-ray department, occupational and recreational departments, etc. Although some of these medical assistants give insulin and shock therapy, these duties are performed only under the supervision of a doctor.

### Working Hours and Vacation Time Liberal

Technical personnel work six hours a day; although they work six days a week, their monthly schedules provide a maximum of only 25 working days. Since there are bound to be slight variations, technical personnel average between 140 and 150 working hours each month. Non-technical employees work eight hours a day for a total of not more than 182 hours a month. All technical personnel, including medical assistants and doctors, get 36 days' paid vacation a year, except those in the children's department, who get 48 days a year. (I do not know whether "sick leave" and holidays are counted in these totals.)

The chief of administration estimated that the turnover of full-time personnel is less than 5% a year. At Kashenko and elsewhere I was told that an employee may quit his job and will usually have little difficulty in finding work elsewhere. This may or may not be accurate. Most new employees are obtained from government-operated "trade schools." There is tremendous respect in the Soviet Union for work specialization and people go to school to learn all sorts of trades, including rather simple ones. It is doubtful if many people change their trades later.

I was surprised to hear that the hospital occasionally advertises for personnel to fill vacancies. I could not, however, find any evidence of such advertising. For the most part the hospital gets cooks from the cooks' school, nurses (medical assistants) from the nurses' school and so on.

About 52% of the hospital budget goes to salaries; food accounts for a further 20%; utilities (gas, coal, electricity and water) 8%; medical supplies 5%; clothing 4%; maintenance supplies 3%; entertainment expense 3%; books, periodicals, etc. 2%, and the remaining 3% is categorized as "miscellaneous."

The total annual hospital budget is thirty-six million rubles, which means 41 rubles per patient per day. Of this, 8.06 rubles are spent for food. These costs, within a range of 10% one way or the other, are average for any mental hospital in the Soviet Union.

It is difficult to compare rubles with dollars. The official tourist rate makes the ruble worth ten cents; there is another official rate (presumably for foreign trade) which makes the ruble worth twenty-five cents. Rubles can be purchased on the open market in Switzerland for about three and a third cents. If therefore the tourist rate is used, the per diem cost at Kashenko was $4.10 per patient, including 80¢ for food. If, on the other hand, the so-called free market rate of exchange is used, the per diem cost drops to about $1.36, including a food cost of about 26¢. The average unskilled worker in Moscow earns about six hundred rubles a month.

My visit to the hospital included a tour of many buildings of various ages. The oldest building in use today was constructed early in this century—the newest is less than two years old. No buildings were under construction while I was there, but I was told that more are being planned to replace existing buildings considered obsolete.

By American standards, the quality of new construction at the hospital is poor, but the style, materials, workmanship and design are on a par with current Soviet apartment house construction. Typically, construction starts with foundation walls of precast concrete slabs, many, many times larger than the concrete blocks used in inexpensive construction in this country. Side walls are usually made of large prefabricated concrete sections, partially hollow, containing a small amount of steel rod reinforcement. Sometimes these side walls are made on the site out of brick or tile. Beams and floors are factory-made precast concrete slabs. Close examination of edges of the slabs showed a poorly mixed aggregate with many sizes of stones and gravel inadequately bonded with cement. Even ten-story buildings contain very little steel. Exterior concrete walls are painted.

### Cleanliness and Maintenance Outstanding

I have visited mental hospitals in ten different countries, and have found none as clean and as well-kept, both inside and out, as Kashenko. Maintenance and upkeep were uniformly excellent. Simple repairs are done by the hospital maintenance department—larger repairs by an outside organization. The hospital grounds are as immaculate as the inside of the buildings. Some wards open into large fenced yards containing benches and some play equipment. Fences are mostly wooden and unattractive and some yards even have high concrete walls. However, most of the grounds are attractively landscaped, with large areas of flowers, shrubs and trees—and the inevitable statue of Stalin.

There are a small number of apartments on the hospital grounds where about 10% of the employees live. At first I was told that those who live on the campus are picked at random, but further discussion elicited the fact that they are chosen in the traditional fashion, the apartments being assigned to those whose duties require their constant presence. There is little financial incentive for an employee to "live on grounds" because rent is an insignificant part even of the common laborer's budget.

The hospital does not have its own fire department. It calls upon the City Fire Department if necessary,

but there is no record of any serious fire for many years.

It has been reported elsewhere that there are approximately 160,000 psychiatric beds in Russia for a total population of about 220 million. In a long discussion with the Chief Administrator of Kashenko, Mr. Bogdasarov, and one of the staff physicians, Dr. Anna Kazarovshya, I tried to explore the reasons for this much smaller proportion of psychiatric beds in Russia than in the United States and other Western countries. One obvious factor is the absence of seniles and alcoholics in the Russian mental hospitals. We were also able to agree that, since there is a much larger proportion of the Russian population living in rural communities, it is probably true that many mentally ill people, who in this country would be hospitalized, can make an acceptable, though marginal adjustment in their homes.

There is no doubt that from one culture to another there is a wide difference of opinion as to what constitutes an emotionally disturbed person. In our society, psychiatrists treat individuals whose behavior would be ignored in a second society, punished by a criminal court in a third, and in still others, be given over to priests. In the Soviet Union today other governmental agencies care for individuals with some of the problems that would lead similar individuals in the United States to mental hospitals.

There is much room for speculation here, since the only figures available are on the number of psychiatric beds in the country. It was freely admitted, however, that if more beds were available they would certainly be used by mentally ill people who are now in the community.

### Russians Admire English "Open Hospitals"

I was interested to learn that a number of Russian psychiatrists have recently visited England and returned with enthusiastic reports of the English "open hospital" concept. There seems to be a strong desire on the part of some of these psychiatrists to experiment with the English pattern.

I suppose my most vivid impression of Kashenko was one of surprise. How is it possible to have such fine hospital care under a government which we have been led to believe is completely uninterested in the individual except as he serves the state? Perhaps the Russians believe that it is cheaper and more efficient to cure the mentally ill and return them to work. Whatever the reasons, the prevailing philosophy at Kashenko is that its patients can either be cured or improved sufficiently to return home within a short time. There is an atmosphere of "tender, loving care" and staff members seem to be genuinely dedicated to their jobs and to the basic hospital philosophy. It is not regarded as a failure if the treatment process requires a number of short periods of hospitalization; since the hospital is only one phase of the total treatment, the high readmission rate is not considered abnormal. There is certainly curiosity about mental hospital practices in other parts of the world, but I sense a reluctance to seek information outside of official channels.

# USES OF THE PAST

## V. *Architecture as Therapy (1752-1803)*

ALTHOUGH ARCHITECTURE as an adjunct to the treatment of the mentally ill has played a role of great importance, its use has, of necessity, been largely dependent on the medical and philosophical thinking of the times. There was no need for any planned architecture during the years when the insane were considered both incurable and insensitive. At that point, any cell, no matter how primitive or barbaric, which successfully contained the unfortunate inmate was acceptable. There were two important trends which were to bring about a profound change in psychiatric care: first, a humanitarian approach, which recognized the mentally ill as fellow human beings, and second, the growing realization that mental illness was within the domain of curative medicine. When these attitudes were coupled with the growing importance of hospitals in general, movements for proper accommodations were inevitable.

This situation meant that the potentially dangerous patient was transferred to a hospital from the jail or workhouse, while the harmless patient was taken from his custodial status in the poorhouse.

It is significant that of the two patients initially admitted, on Feb. 11, 1752, to the Pennsylvania Hospital, the first hospital in the country, one was mentally ill. There had, however, been little improvement in architectural considerations, for such patients were kept largely in basement cells. In 1756, when the Pine Street Hospital opened, they continued in the cellar, but with certain improvements. The plank floors were placed over arches to decrease dampness and avoid rats. Windows at the ground level permitted an easier influx of light and air, but also unfortunately allowed for sightseeing on the part of the local populace. A similar situation existed at the New York Hospital, where the bulk of the patients were located in the cellar, although some were scattered through the general medical wards.

The next important architectural step was the opening of the Eastern State Hospital in Williamsburg, Va., in 1773. Here, for the first time, was constructed a separate building entirely for the psychiatric patient. It was rectangular in shape, two stories high, and contained 24 individual rooms with about 126 square feet in each. There was also an enclosed yard where the patients could have sheltered outdoor activity and recreation. The managers apparently were fortunate in not being burdened with overcrowding for some years.

The movement towards construction of better quarters advanced in 1796 when the Pennsylvania Hospital erected a separate wing for the treatment of its insane. Although this represented a great improvement, the hospital still struggled until 1833 with such problems as inadequate heating.

In 1803 the New York Hospital trustees debated between building another wing or adding a story, and finally settled for the latter course. This expansion brought temporary surcease of the space problem, but the movement for a separate building continued until one was completed five years later.

ERIC T. CARLSON, M.D.

# The Patient's Closest Associate

By DORIS C. RAUB
Psychiatric Social Worker
St. Louis State Hospital, Missouri

A PATIENT ENTERING a mental hospital is entering a strange new world of several thousand people. The rules and customs of this world are different. He moves, not as an individual but as one of a group—to meals, to bathing, to occupation and so on. Doors are locked behind him, giving him the feeling of being trapped in a situation beyond his control. He wonders if they will ever open outward for him again. The people, too, —doctors, nurses, social workers, activity therapists—are different from his lifelong friends and associates and they all seem to be doing unfamiliar things. Where is he to find some familiarity—some reassurance?

There is perhaps just one group of people with whom this new patient can establish a seemingly familiar and safe relationship—the attendants who see him and work with him personally for twenty-four hours a day on a continuous basis. The attendant can be like a parent looking after the welfare and physical needs of the patients in his care. He is responsible for the physical environment, and for carrying out and explaining the orders of the doctors and nurses and other personnel. Best of all he is engaged in activities which seem to the patient to be "normal" and useful.

### Attendants' Value Often Unappreciated

Yet these key figures in the patient's hospital life are too often given the "serf role" in the institution, drawing the lowest pay, doing the dirtiest jobs and often receiving the least amount of appreciation. The "professionals" on the team tend to deprecate these knowledgeable and important people, neglecting to share their ideas about the patient and how he may be helped. Yet the attendant's contribution to the welfare of the patient depends to a large extent on the kind of relationships he has with the professional people involved in the patient's treatment.

True, some attendants may have only a limited education, but this does not mean that they do not have the capacity for warmth and the ability to grow in their understanding of patients. It is therefore important for all the professional people to coordinate their efforts with all who contribute to the welfare of the patient and accord each individual his proper place in the total treatment program.

"I should think that she, with all her training, would have been taught that I'm a human being too," commented one attendant about a social worker. Attendants don't form opinions about the professional staff as much from their knowledge and training as they do from their conduct!

The professional going onto the ward about a particular patient and asking the attendant for information often fails to realize that this is a ward of seventy or more patients. The attendant has already had to feed and bathe many of these patients, look after the ward housekeeping, make the beds, clean the floors, answer numerous questions from other personnel and settle fights and other disturbances among patients. He is not to be blamed if this last inquiry is the straw that breaks the camel's back. He was ready to explode before the situation arose.

When the professional, therefore, demanding the attention of this overworked individual, meets with obviously forced cooperation, he is puzzled and confused, and fails to understand why the attendant became so upset about such a simple request or inquiry. It's easy to be unaware of the tension and irritation the attendant suffers because of the frustrations of a full day working with patients, other hospital personnel and visitors. He seldom gets a chance to express his feelings, and fearing to lose his job if he does not cooperate at all he sometimes gives an irritated, half-hearted response. The attendant, lacking a professional background, may not understand a good many things. An untidy patient can be particularly upsetting to him. The man eats, sleeps well, talks coherently, and apparently there's nothing wrong with him. So why is he untidy? A paranoid who looks normal and talks rationally may seem to the attendant to be so well that he wonders why this patient is in a hospital. How does he know how to relate to this seemingly normal individual unless he is given some assistance in understanding the problem?

### Onus on Professional Personnel

The onus is on the professional personnel to increase the skills of the attendant by sharing with him their purposes, aims and values. They must keep in mind that ideas which are important to them because of their training are not always accepted as important by people without this background. Thus explanations should be in practical, rather than theoretical or philosophical terms.

When an attendant fails to understand the purpose of a particular procedure, for instance, it is difficult for him to cooperate fully. The following incident illustrates how such lack of understanding can lead to bad feeling between attendant and professional:

*A patient had the feeling of being "stuck." Her mother had told her early in life that she was stuck with her as well as with her five other children. While in the hospital this patient became disturbed and was placed in wet pack sheets. She became quite warm and began to say that she felt as if she had returned to her mother's womb. The professional worker who was present grasped*

*the situation for what it was and began to slowly unwrap the patient, very gently telling her, "You are not stuck. I am going to let you out. You are not stuck." This unwrapping became a most important step in the treatment of the patient.*

*However, the attendants present observed only that a rule—a patient should not be released from the pack until the alloted time is up—had been broken. Other patients in packs began to demand their release too. The attendants were angry, perplexed, and confused because of the lack of understanding of what had been done. The whole ward was in a turmoil.*

Professional personnel have a special responsibility for helping the attendants to understand that the rules are made only for the welfare of the patients, and that they may be broken if necessity arises.

Too often professional people talk exclusively to the patient, without consulting the attendant, and therefore may fail to get vital information about the patient's behavior. The attendant hesitates to volunteer unless he's asked. He may not know much about the dynamics of personality development, but he does know that John became angry with Paul and struck him. Perhaps John had never before been able to express hostility and this would have been an important piece of information for treatment purposes. What a pity the professional worker failed to get it. Without encouragement, every attendant doesn't have the intiative to report information which he himself can't evaluate.

Finally, the greater recognition the professional staff gives to the attendant's role in the treatment of patients, the more the attendant's conception of himself will improve, and his ability to work successfully with the patients will increase.

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## ". . . and Good Will Toward Men"

The opportunity to share with the community in Christmas giving brings a great deal of satisfaction and happiness to patients at Topeka State Hospital, Kansas.

Throughout the year patients are busy cutting out, sanding, and painting colorful pull-toy animals, small chairs, and stick horses, to give to non-profit children's organizations at Christmas time. About 90 patients participate in making the toys each year. Those with small children may also send some toys home if they like.

Since the hospital budget is too limited to supply new materials, the patients use wooden packing boxes, broken furniture, and scrap lumber left from hospital repair projects, as well as odds and ends of lumber donated by community business establishments. Construction in the woodworking therapy shop is on a production line basis, with each patient's activity prescribed by the doctor. The more integrated patients operate electric saws; others assemble parts, sand, or paint.

One Christmas when the local TV station appealed to the public for gifts to send to hundreds of ill-fed, poorly housed Navajo Indians in Arizona, Topeka State Hospital patients donated many toys they had made. In a news item describing the little Indian children's reactions when they received the gifts, a reporter on the Topeka Daily Capital wrote: "The most heartwarming gesture of all came from a group of patients at Topeka State Hospital who donated 1004 wooden toys they had been building and painting all year. When they were unloaded at Fort Defiance Navajos and mission workers treated them with special care. The children's eyes became even brighter when they saw them carefully stacked near the orphanage."

**MRS. LETHA SWANK**
**Director of Public Information**

# Conference Reports

### INSTITUTE AT OSAWATOMIE STATE HOSPITAL

A three-day meeting on the "unitary concept" of mental illness attracted 250 psychiatrists from 25 states and Canada to the Osawatomie State Hospital in Kansas during the first week in October. Dr. Karl Menninger, Medical Director, and Dr. Ludwig von Bertalanffy, biologist, of the Menninger Foundation in Topeka led off the discussions, which were programmed as concerning the study of the schizophrenic types of mental disorder.

"We should think of all mental illness as being essentially the same in quality, differing in quantity," said Dr. Menninger. "The patient is not one afflicted with a certain disease which must be named and battled with, but rather a human being somewhat isolated from his fellows, whose relationships with them have become mutually unsatisfactory and disturbing."

### N. J. SIXTH ANNUAL PSYCHIATRIC INSTITUTE

As a gesture of appreciation the sponsors of the Sixth Annual Psychiatric Institute dedicated it to Dr. Robert S. Garber, former Medical Director of the New Jersey Neuro-Psychiatric Institute, under whose auspices the series was started in 1953. Theme of this year's meeting was "Modern Viewpoints in Research," which provided the discussion material for eight scientific papers presented during the Institute.

A high point of the meeting was the presentation of the first annual Nolan D. C. Lewis Award for Psychiatric Research to Paul H. Hoch, M.D., New York State Commissioner of Mental Hygiene, for his outstanding contributions to the field of neuro-psychiatry.

### NORTHEAST STATE GOVERNMENTS CONFERENCE ON MENTAL HEALTH

Dr. Francis J. Gerty, President of the American Psychiatric Association, was the key speaker at the Northeast State Governments Conference on Mental Health held October 9 and 10 at Swampscott, Massachusetts. Dr. Gerty's subject was "State-Community Relations and Resources in Mental Health," the theme of the two-day meeting. He emphasized the importance of community action in improving mental health care, and stated that professional mental health workers have a duty to communicate their needs. He also pointed out that facilities for treatment should be geographically close to where illness originates and asked for closer coordination and integration between community mental health centers and mental hospitals. Other featured

speakers were Dr. Jack R. Ewalt, Commissioner of Mental Health for Massachusetts, who addressed the group on "Current Trends in Mental Health," and Mr. Earl Ubell, Science Editor of the New York Herald Tribune, whose topic was "Interpreting Mental Health Activities to the Public."

Dr. B. R. Hutcheson, program chairman, explained that the purpose of the conference between mental health specialists and government representatives was to exchange information on new developments in mental health and discuss methods of improving mental health programs through government action.

# READERS' FORUM

## Farm Work is Not Therapeutic . . .

I don't usually write "letters to the editor," but in the last NEWSLETTER there was a provocative little comment about the feasibility of state hospital farms.* It has been one of my pet peeves for a long time. During the time I was Commissioner of Mental Health in Kentucky, the farm was a constant problem and seeing this in print was sort of like blowing a bugle at an old warhorse.

From an historical standpoint it is easy to see how state hospital farms evolved. In years past there was simply not enough money, and with free patient labor food could be more cheaply raised than it could be bought. Over the years it has been rationalized that this work provides useful "occupational therapy" for patients —and perhaps it did in the past. I think one of the real reasons that these farms have persisted is that many superintendents have been personally interested in them, and also because in many rural states legislators have been able to understand the farm operation but little else about the hospitals, and so encouraged the development and improvement of the farms.

Some years ago we in Kentucky began to set up a system of cost accounting for the farm; we accumulated increasing evidence that it was not actually a profit-making proposition, or else that it made marginal profits even with free patient labor. As time has gone on with shorter hospital stays and consequently fewer able-bodied people to work, the farm has become an increasing problem, especially in urban areas where few people have skills or are interested in farm work. No matter what the advantages may be, the farms take a good deal of the superintendent's time, even though he may have an excellent farm manager and business administrator. In two of the farms in Kentucky, with cities and subdivisions growing around them, we found that we were farming on expensive subdivision land or land that could be used for commercial purposes.

Finally there is the moral question of forced or at least coerced labor versus the use of patients in labor assignments that may have therapeutic purposes. Certainly picking beans in the middle of July, or whenever one picks beans, and working in a hot canning factory has questionable therapeutic value.

I have for a long time advocated that all the state hospital farms be sold and the money used to buy farms to be worked by the state prison; the hospitals could be given enough money to buy this produce, or else to buy food on the open market where surprisingly enough one can sometimes get better prices than the prisons can offer.

It is good to get this off my chest. It will be interesting to know what other people think about this.

FRANK M. GAINES, M.D.

## . . . Nor is Laundry Operation

I am happy to endorse the article "Should Patients Work in Mental Hospital Laundries?" by Mr. Summers (Page 29).

Our interest in a special laundry study stemmed largely from a fuller realization of certain important considerations, among which were the following (not necessarily in order of importance):

Awareness of the markedly reduced patient population now engaged in hospital laundry work. This reduction has come about, obviously, through improved treatment programs and markedly increased discharge rates in recent years.

A desire to eliminate from the hospital such commercial activities as are not intimately connected with the pursuance of progressive and dynamic mental health programs. Except for a very limited rehabilitative aspect, laundry operation constitutes such a commercial activity.

The importance of improving the efficiency and the hygienic measures involved in a more adequate linen supply and linen control system.

The increasing realization that a consolidation of laundry activities should result in savings both in capital and maintenance outlay, and the hope that some of these savings might be available for improved medical care.

The Department of Mental Hygiene in Maryland feels that the study described has gone far to help in the improved efficient, humane and economical management of our state hospitals. I hope Mr. Summers will prepare similar articles based upon the company's most helpful work in the State mental hospital system in Maryland.

CLIFTON T. PERKINS, M.D., Commissioner

# Film Reviews

### HUNDREDS VIEW FILMS AT TENTH MENTAL HOSPITAL INSTITUTE

At 7:15 in the morning of the first day of the 10th Mental Hospital Institute in Kansas City, a few sleepy-eyed people entered the Trianon Room of the Hotel Muehlebach, quaffed coffee and doughnuts, and settled down to watch mental health films. When the lights came on at the end of that morning's program, there were twenty-five people present. Word-of-mouth advertising as to the high calibre of coffee, pastries and films was undoubtedly responsible for the fact that subse-

*See also *MENTAL HOSPITALS, November, 1957.*

quent sessions were better attended. A peak of 110 viewers got up for Tuesday's a.m. program and 100 attended Wednesday's. Afternoon showings were popular, too, with 125 present for the Monday premiere of A NEW CHAPTER, latest film of the Mental Health Education Unit, Smith Kline & French Laboratories, and 50 for the Tuesday screening of BITTER WELCOME, a new production of the Mental Health Film Board.

The programs were profitable to viewers and to the A.P.A. Mental Hospital Service alike, for movie-goers were dutiful about filling out evaluation sheets on the nine new films they saw. We now know much more about the needs and preferences of the mental hospitals serviced by the Film Library. According to the questionnaires, hospitals are now using films chiefly for staff training and would, therefore, like to see more films for this purpose. It happened that four of the films shown in Kansas City were suitable for staff training and one of them, THE INNER MAN STEPS OUT, has been recommended for addition to the Film Library. Although originally intended for use by supervisory management in industry, the human relations techniques outlined in this film are applicable to hospital administrators, who must cope with frictions resulting from staff shortages and high degree of turnover.

Another film on human relations in industry was PRODUCTION #5118, featuring an unusual style of presentation which showed a movie in the making, with actors commenting on the meaning of their roles. Since this film will *not* be added to the Film Library, hospitals desiring to see it should write to: Department of Public Relations, Champion Paper and Fibre Co., Hamilton, Ohio.

Most popular of the training films (in terms of requests for re-showing) was PSYCHIATRIC NURSING: THE NURSE-PATIENT RELATIONSHIP, which traces a developing relationship between a nurse and one of the many patients in her care. This film is now available on a free-loan basis from Smith Kline & French representatives.

In answer to requests for more rehabilitation films, two were shown. A NEW CHAPTER is unique in that it is intended for showing to patients before or after discharge as a means of eliciting discussion on the patients' feelings about returning home and of motivating patients to seek out and make use of after-care services provided in their communities. Not a realistic picture of an actual patient's discharge experience, the film is rather an attempt to pictorialize the hopes and apprehensions of a patient, so that he will be able to talk about his feelings with hospital personnel before he leaves the hospital. A NEW CHAPTER will also be useful for showing to relatives and friends of patients to help prepare them for the patient's homecoming. This film, which was reviewed in these pages last month, will be available around February 1, from Smith Kline & French representatives.

The other film about the patient's return was BITTER WELCOME, which has already been added to the Mental Hospital Service Film Library and was reviewed in the September issue of *MENTAL HOSPITALS*.

Also shown were THE KEY, made by the National Association for Mental Health to show the public how they can help to solve some of the problems now facing mental hospitals, and THE MAN WHO DIDN'T WALK, intended for showing to physicians to acquaint them with some of the problems of legal testimony when a case is complicated by a psychiatric factor.

Not precisely a film, but a filmed record of a television program, was TROUBLED PEOPLE MEET, showing Dr. Jerome Frank leading a group psychotherapy session at the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital. This kinescope, the only existing record of the program, was made available to the institute through the kindness of Dr. Frank, and is not available for borrowing. Several people expressed a desire to see it re-made as a film and this suggestion will be passed along to film producers.

Other suggestions for film subjects which will be relayed to producers are: alcoholism, mental retardation, vocational rehabilitation of the mentally ill, interviewing techniques, the geriatric patient, and the dynamics of behavior. It is to be hoped that the roster of films for next year's institute will include films on these subjects. Even if it does not, two things are certain (viewed from six years' experience in showing films at the institute): namely, more producers are making better films about mental health, and more people are getting up early in order to see them.

JACK NEHER

**Many Hands Make Light Work**

**The Rehabilitation Center at Parsons (Kan.) State Training School provides a homelike setting for teaching the principles of good housekeeping to girls who may someday be working in homes—possibly their own. Students are shown learning to use an electric range, one of the many modern appliances provided in the cooking laboratory. Girls (and some of the boys, too) learn to cook, to freeze food, to prepare well-balanced meals and to be good hostesses. Classes are held daily in line with the superintendent's belief that the retarded child learns best by doing and doing often.**

# The Use of Patient Help in Mental Hospital Laundries

By THOMAS SUMMERS, Executive Vice-President
Victor Kramer Co., Inc., Laundry Management Consultants
New York City

VICTOR KRAMER COMPANY has for many years served as laundry management consultants to mental hospitals operated by several state and county governments. This article is derived from continuing studies made by our company in the mental hospitals of the State of Maryland. We do not presume to draw conclusions on the use of mental patients in laundries, but only to present an objective discussion of the issues involved.

### New Perspective Needed

Important developments in recent years demand a new perspective in regard to the question of patient help in the hospital laundry. The trend towards shorter hospitalization and the increased possibility of reducing the backlog of chronic patients are both factors which will affect the consideration of whether or not it is advisable to employ patients in the laundry, or, for that matter in any of the supporting service areas of our mental hospitals.

Until now the principal arguments for using patient help have been that the activity provides (1) economic benefit for the hospital and (2) therapeutic help for the patient. To the extent that patient helpers can effectively replace paid employees, the economic advantages are obvious. As to the therapeutic benefits, medical opinion varies; there is no authoritative consensus. The arguments in favor of it run along these lines:

"The work is good for the patient. When idle, he suffers from feelings of uselessness, monotony, loss of personal dignity. Purposeful work restores his self-assurance. He gains status recognition working side by side with regular employees 'from the outside.' He develops a sense of 'belonging,' becomes a useful member of a working team, practices cooperative effort with others, responds to the mild discipline of a crew. Here he finds himself wanted and welcomed. He gains confidence that he can really do a good job. He spends several hours a day in a normal, industrial atmosphere, practicing good work habits, accepting small responsibilities under guidance. To some extent, the physical effort may release pent-up energies and offer an outlet for some frustrations. Besides, he learns a trade in which he might get steady, decent employment after release."

Opposed to this reasoning are the arguments that (1) the use of patients in the laundry or any other supporting service department of the hospital interferes with the patients' hospital routine, (2) patient helpers are not efficient workers and may even impair the efficiency of paid employees with whom they work, and (3) chiefly, such work has no therapeutic value unless it fits into a pre-planned rehabilitation program.

### What the Patient Can Do

There are at least 30 separate laundry jobs that mental patients can handle in the hospital laundry. They range from easy tasks, performed by men or women in sitting or standing positions, to harder jobs requiring considerable exertion or skill. The easy jobs, such as sorting, shaking, packing and folding, are simple, repetitive, and easy to learn; they call for few decisions and involve no hazards. The more difficult jobs are those of loading and unloading laundry into and from machines, pushing and cleaning equipment. The skilled jobs include pressing, weighing, sewing, and clerical work.

Assignment to the various categories of jobs should be decided by physician or industrial therapist, based on their judgment of the patient's physical capacity, emotional stability, and general aptitudes. Placement in a specific job within the recommended category should be decided by the laundry manager.

### Paid Workers for Hazardous Jobs

Complementing and working with the patients, of course, would be paid employees (professional laundry people, usually on civil service). They would be assigned to the jobs requiring superior judgment and involving more hazards: they would start and stop machines, turn on and off electricity, steam and water, open and close valves, press buttons, control operation. Primary functions of the paid employees would be to counsel, teach, supervise, and direct the patients in performing tasks.

Much can be done, of course, to minimize whatever adverse effect patient-helper deficiencies may have on efficient laundry operation and to extract the greatest benefit from their efforts.

For example, it is essential, primarily, to establish a fixed work week with regular, assigned hours. This permits orderly scheduling of conferences, treatments, and social activities during the patients' days off, probably designated at the convenience of the medical staff. The main thing is to predetermine the workdays and the non-work days.

As to the nature of the work week, it is important to keep it (a) short enough to minimize patient strain or fatigue, yet (b) long enough to benefit the patient therapeutically and the laundry economically. Thirty hours is

the general optimum. This would consist of five six-hour days.

To set up such a schedule naturally requires good interdepartmental liaison and cooperative, give-and-take attitudes among medical, social, industrial therapy, and laundry staffs. It also requires the firm, coordinating hand of a judicious administrator such as the executive director or business manager or other appropriate authority.

Less debatable than the possible therapeutic value of laundry work are the economic advantages; these can be seen in dollars and cents. The chart illustrated on this page is based on the actual combined operating figures of five mental hospitals in Maryland.

Some of the prevailing attitudes we have found in the Maryland hospitals are as follows:

In general, the medical staff rather disapproves of such use of patient help. While they may, in varying degree, consider the laundry work of some therapeutic value they are more concerned with the patients' hospital routine. The medical staffs dislike the administrative bother involved in scheduling patient help. Physicians want the patients immediately available for examination, treatment or conference, and so object to activities that interfere with this routine. Toward this end the medical staffs advocate: "Accelerate treatment by psychotherapy, tranquilizing drugs, and other methods to get the patient out and back to normal life as early as possible. Leave the laundry and other hospital services to paid workers."

Hospital costs are quite properly, the primary concern of the business managers. They are managing large businesses and earnestly want to operate efficiently. They know that patient help is, at best, inefficient, an obstacle to standardized methods. But they also know, better than anyone, how laundry costs would skyrocket if patient help were to be replaced by more and more paid employees. So they generally favor the use of patient help for laundry, maintenance and dietary departments.

Laundry managers, are experienced laundry technicians who want high production, no absenteeism, smooth discipline, and responsive, skilled workers. With the headaches involved in the use of patient helpers, laundry managers, if given a choice, would prefer not to use patient help at all, but rely, instead, on trained, paid employees.

But laundry managers are aware of budget limitations, too. So they try to make do with help from patients. Almost invariably, laundry managers cooperate fully with the medical and business staffs.

Traditionally, those have been the prevailing – and opposing – attitudes. But conditions are changing, thanks to medical advances, and, as a result, so are the problems. Therefore, it may be of interest to both medical and administrative staffs of all mental hospitals to know how Maryland hospitals are coping with these changing conditions and solving the problems that inevitably accompany them.

### The New Problems

Patient help is shrinking. The number of patients assigned to duty in the laundries, along with total patient man-hours worked and their total productivity, are all diminishing.

Formerly, a large number of chronic, long-term patients helped in the laundry. These people were considered relatively permanent, not likely to go out again into the community. Some of them became good workers. Others merely went to the laundry for lack of somewhere else to go; they received meager instruction, worked sporadically, accomplished little. Still, there were enough hands to get the job done.

Today these old-timers are disappearing. With the wide use of tranquilizing drugs and other advanced procedures in psychotherapy, almost 50 per cent of mental patients are discharged within a year after admission. Many of those remaining are senile, not physically able to do industrial work. Others are simply not interested in learning a trade such as laundry work. And, of those who are both fit and willing, some are held available for frequent treatment, conference, and attention by the psychiatric staff. With patient help on the wane, various hospital departments vie for the services of those who are available.

If this trend continues, additional paid employees will have to be hired to get the work done. The added cost would be a heavy burden on the hospitals.

### FOUR POSSIBLE SOLUTIONS

Depending on the hospital's objectives, there are four possible solutions:

1. Continue to use patient help.
2. Use only selected patients.
3. Employ only paid, classified workers.
4. Use nonpaid outside help, such as prisoners.

Specific commitments of each institution will, of course, determine which course to take. Here, for guidance purposes are the pros and cons of each possibility, based on our many years of experience with, and direct observation of mental hospital laundries.

### 1. Continue to Use Patient Help

To some hospitals the drawbacks to the use of patient help have seemed overwhelming. Besides the already-mentioned interruptions in hospital routine, there is the relative inefficiency of patients as productive workers. The most common difficulties include:

Irregular attendance, frequent absenteeism. In one hospital with 90 patients assigned to the laundry, only 60 can be expected to be available

**Patient vs. Paid Labor—an Economic Comparison**

| | Number of Patient Helpers | Number of Paid Employees | # Annual Payroll | Decrease in Payroll | Increase in Payroll |
|---|---|---|---|---|---|
| At time of survey | 242 | 67 | $200,000 | | |
| If patient help increased 50% | 363 | 57 | $170,000 | $30,000 | |
| If patient help decreased 50% | 121 | 112 | $335,000 | | $135,000 |
| If patient help were eliminated | 0 | 150 | $450,000 | | $250,000 |

# Based on average of $3,000 per annum per employee.

for work on any one day. In another hospital, only 30 out of 50 show up.

Short term of duty in laundry. Before the patient is trained to do one job well he is transferred out of the laundry department.

Interrupted day. The patient starts to work in the morning, is called away in a couple of hours. Interdepartmental phone calls are frequent. As a result, scheduling of work deteriorates into a hit-or-miss thing.

Extended lunch periods. With the midday meal spread over two hours on a staggered basis, some patient helpers leave every few minutes, interrupting work and wasting administrative time. More important, such interruptions make for bad work habits, negating the value of training and leaving the patient unprepared for work in the outside community.

Yet, despite all these obstacles, a very strong case can be made for using patient help. There is no question about its being economical, and the possible therapeutic advantages have already been discussed. Apparently, the hospitals that employ patients in the laundry feel that such work does spur recovery.

But if such a program of therapy is to be followed, patient placement and training is best sponsored, directed, and coordinated by an industrial therapy department. The industrial therapists have a direct interest in the patients, and this interest creates a sympathy which becomes a foundation for understanding. The laundry work becomes a meaningful phase of an over-all rehabilitation program.

### 2. Use Only Selected Patients as Helpers

Basically similar recommendations would apply. But instead of increasing the number of patients employed in the laundry, hospitals would screen prospective laundry workers more carefully, hand-picking chronic, long-termers to train, and thereby obtaining a better quality of patient help. It is interesting to note that better results are obtained with mentally retarded patients rather than emotionally disturbed patients doing the routine laundry tasks.

A variation sometimes suggested is to provide for the bulk laundering of flatwork (bed linens, towels, etc.) by paid employees, prisoners, or outside commercial laundries; then to utilize patient helpers to launder wearing apparel by manual ironing methods. But such sub-division is generally uneconomic and creates administrative complications.

### 3. Employ Only Paid, Classified Workers

This third alternative involves no patient help whatever. Those who favor it advocate the exclusive use of all medical means to return the patient to society as soon as possible.

If such an arrangement is adopted, however, the hospital must be prepared for a sizable addition to its budget. True, a skilled employee can do the work of nearly three patient helpers. But the average annual wage of a classified laundry worker is some $3,000. For quick calculation, figure the worth of each patient helper's work in the laundry at about $1,000 a year. Thus, if you intend to replace

60 patient helpers with 20 classified, paid employees, add $60,000 to your laundry budget.

This additional burden *can* be reduced however. It can be done by stepping up production. Increased laundry production, like any effort toward improved efficiency, is essentially a management problem. Basically, this problem calls for a two-phase program of (1) mechanization—substituting machines for men and (2) maximizing manpower—getting the most out of those who cannot be replaced.

In mechanizing, full advantage should be taken of the many labor-saving devices now available; e.g., high-speed presses, conveyors, flatwork conditioners, automatic sheet folders and spreaders, small-piece stackers, unloading washers and extractors.

In maximizing your manpower you first establish job classifications and pay rates to reflect skills and productivity and then set up production standards and require specific performance for each worker.

### 4. Use Nonpaid Outside Help Such as Prisoners

Both the theoretical and practical aspects of this alternative are discussed here as a desirable policy in the event that prevailing medical opinion rules out the use of patient help in any degree and that budget limitations preclude the exclusive use or even the addition of supplemental paid workers. In Maryland, New Jersey and other states and counties, too, the trend is now strongly toward removing laundry work from the mental hospitals, sending it to correctional institutions or prison colonies, there to be processed by prisoners.

*Some Advantages:*

a. Trained prisoners are more efficient laundry workers than patient helpers. We have found, for instance, that prisoners assigned to press work turn out exceptionally high production. The majority of them work well under supervision and do their jobs in a quiet, orderly way.

b. A more efficient laundry run by trained prisoners makes it possible to provide such extra services as pressing patients' garments, thereby improving the patients' appearance, self-respect and, consequently, their morale.

c. It costs less to house, feed, guard and employ prisoners than to hire paid, classified laundry workers.

d. Prisoners themselves may be rehabilitated by learning a useful trade they can use when returned to the outside world. Meanwhile, their morale is improved and the activity provides an aid to disciplinary control.

e. Many authorities believe that mental hospitals should refrain from operating such services as are not intimately concerned with the therapy of patients. "Laundry" is a classic example. If it is handled by prisoners, hospital administration stays out of the laundry business.

Clearly, the decision for any one of the solutions suggested will rest on many factors peculiar to the needs and objectives of the individual hospital. The "right" decision is a synthesis of the conscientious recommendations of every department head concerned—medical, business, personnel, laundry.

# WOMEN FIRE FIGHTERS PROVE THEIR WORTH

By GENE FOREMAN
ARKANSAS GAZETTE Staff

FIVE WOMEN EMPLOYEES of the Benton Unit of the Arkansas State Hospital surprised Unit Fire Chief Franklin Johnson a few months ago by signing up as volunteer fire fighters.

The unexpected applications also astonished Ralph W. Scantlin, Hospital Fire Marshal and Safety Engineer, who had called for volunteers to help the Benton Unit's seven-man Fire Department.

Since it was Scantlin's job to instruct the new volunteers, he was allowed to decide whether to accept or reject the women's applications. He admitted that he was reluctant at first. But the women argued so convincingly that his resistance melted.

"They told me," he explained, "that they had jobs and homes at the hospital which they ought to protect. They insisted that they be allowed to serve just as anyone else. So I let them enroll."

After watching the women in action at the weekly training sessions, neither Johnson nor Scantlin regretted the decision. "It sure turned out fine," remarked Scantlin. "They've proved that there's a lot of things they can do to help fight a fire."

Women Volunteer Fire Fighters at the Benton Unit of the Arkansas State Hospital, demonstrate the use of fog streams on a lacquer and paint thinner fire, during fire fighting class.

### Same Training

The women fire fighters receive the same training that Scantlin gives to the eight male members of the volunteer class. That includes such sturdy tasks as connecting and disconnecting hoses, spraying fires with the hoses and working with the pressure pumps.

Mrs. Lena Coleman, one of the volunteers, rejected the idea that such work is too burdensome for a woman to handle. "We really enjoy it," she said. "It's quite pleasant—and fascinating."

The other volunteers don't seem to mind this invasion into the male domain. Instead they appear awed by the skill of Mrs. Coleman and her colleagues. One male volunteer, B. H. Heard, commented about the speed with which the ladies "caught on" to Scantlin's lesson on starting the pressure pump. "It just seems they learn faster than the men," he observed.

Mrs. Coleman and the four other women—Mrs. Helen Hensley, Mrs. Violet Kitchens, Mrs. Vivian Cochran and Mrs. Ruth Friday—work as ward aides at the hospital. Scantlin believes they are the only women volunteer fire fighters in the state.

The volunteers will help Johnson and his men guard the hospital buildings which stand on a 400-acre plot of rolling woodland near Benton. The Department owns a 750-gallon pumper equipped with three 125-gallon booster tanks. "Our firemen have to be skilled in all kinds of fire fighting," Johnson said. "We can't specialize here the way the city firemen do. We're a ladder company, pumper company and everything else all rolled into one."

### On Call 24 Hours

A blast on the pumphouse whistle is the signal for the volunteers to scramble into action. They are on call 24 hours a day. The part-time firemen train under Scantlin two hours each week. During the two-year course, they and another class of 15 will be schooled in all aspects of the fireman's trade. For their efforts, they will be credited with a day's work for each four class periods and will be exempted from a basic fire prevention course required of other employees.

The women volunteers aren't exactly looking forward to their first fire—they wouldn't wish misfortune on anyone—but they're still anxious to put their training into practice.

"When the time comes," Mrs. Coleman promised, "we'll show what we've learned."

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*This article is reprinted from the ARKANSAS GAZETTE*

# PSYCHIATRIC AND DETENTION WINDOWS

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# Conversion of Old Buildings to New Uses

By CHARLES E. GOSHEN, M.D.
A. P. A. Architectural Study Project, Washington, D. C.

MODERN ARCHITECTURAL, engineering, social and psychiatric progress are all combining to render many of the existing mental hospital facilities obsolete. The vast majority of institutions in use today were designed and built during an era which was dominated by the desire on the part of the public to make mental institutions as obscure, as isolated and as economical as possible. They are usually too large and invariably lack the facilities which we consider necessary in a modern mental hospital.

Although many of these old buildings are unsafe, unattractive, unmanageable and reeking with the accumulation of unpleasant odors which have soaked permanently into the porous texture of floors and walls, it is unlikely that very many of them will be torn down in the near future. Instead it is most likely that they will either be converted into more modern treatment and administrative facilities, or remodeled into more presentable housing for patients.

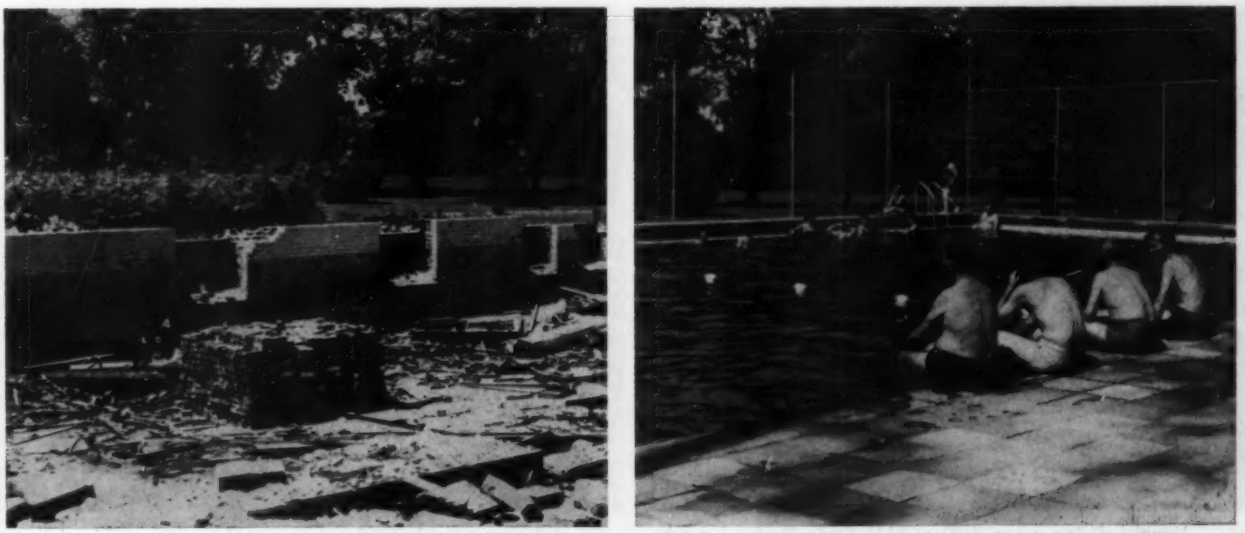
### Deficiencies and Possible Solutions

Buildings erected prior to 1925 demonstrate a number of characteristic deficiencies, most of which can be remedied; the rest must be endured. Probably the only really insoluble problems are the number of stories—generally from three to five—and the general unattractiveness of the exterior, especially the amount of superfluous and ugly ornamentation.

It is not our intention in this paper to discuss such obvious innovations as fireproofing, bringing up-to-date plumbing and electrical installations, installing elevators, increasing the number of entrances and exits, making the best use of the long, wide corridors, and arranging for adequate ventilation, heating and lighting, both natural and artificial. Rather, we hope to draw attention to problems often thought to be insoluble but which can be solved with a little ingenuity and the use of modern materials and techniques.

The high ceilings—12 feet or more—which are characteristic of these old buildings are not only acoustically bad, but their loftiness causes the unhappy patient to feel even more "cut down to size." Elevating the floors of these old rooms not only lowers the ceiling, and brings window levels closer to the floor, but also provides space for the needed electrical, heating and plumbing installations. New ceiling treatments are becoming available, too. The trend is away from the recessed beam ceiling, and toward a flush ceiling which provides a dead air space above for duct work and conduits when necessary. One of the best new materials used for this purpose is aluminum framing encasing Fiberglas panels. These panels can be easily removed to reach pipes and wires, and the whole assembly is both fireproof and soundproof. Other ceiling treatments include the use of Celotex and aluminum panels.

Old wooden floors resting on wood joists or fastened to wooden sleepers imbedded on concrete are unsightly and collect odors. Troweled vinyl composition can be used to cover these floors; this process semi-fireproofs the wood floors, makes for easier maintenance and greater attractiveness and, having no joints, prevents water and



At Evansville (Ind.) State Hospital the basement of a razed building was converted into a swimming pool for patients.

detergents from seeping underneath to cause rotting and the accumulation of odors. Cement terrazzo is another possible solution, except that its great weight poses an engineering problem so far as support is concerned; its rigidity, over non-rigid floor joists, causes cracking so that joints must be created; these joints allow water to seep through. Moreover, the terrazzo type of flooring tends to be esthetically cold, and unsafe when wet.

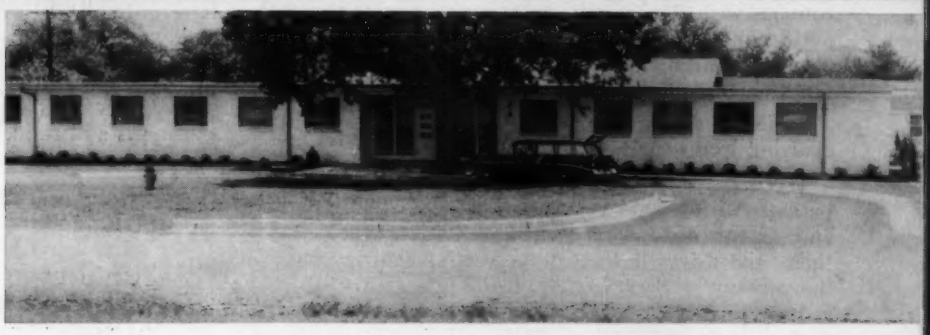
The high-framed windows have already been mentioned; even when elevation of the floor has lowered their customary four-foot high sill, they are still apt to be narrow with many small lights. Metal-frame windows with fewer lights can easily be substituted; they reduce maintenance costs, increase the natural light and permit the view, if any, to be seen. The early examples of metal-frame windows had the disadvantage of leaking air, but the modern seals eliminate this problem.

These old windows, with their emphasis on security, are grossly inadequate in terms of appearance, by modern standards. On many windows today, security screens and bars could be safely eliminated, but where security is considered necessary, high tempered glass or plexiglass is available to create the needed security even without the use of screens. The modern screens, needless to add, are a great improvement on the old-fashioned iron bars!

There are various ways of dealing with the problems of walls and partitions. Ceramic tile is a good wall cover as far as maintenance is concerned, but it is expensive, heavy, and institutional in character. Plywood paneling can produce some attractive interiors and is relatively inexpensive and easy to install. It is not fireproof, however, nor as durable as some other materials. Fabrics of a canvas-like texture are available and can be used to create interesting decorating patterns. They are inexpensive and easy to install, but can be easily damaged. A new product, called "Vitroglaze," is a spray-on material which can cover defective plaster very nicely, and produces an attractive, glass-like finish easily maintained. Other new materials are manufactured in large sheets that can be glued or metal-fastened onto existing walls;

Lowered ceilings, small modern tables and plenty of color transform an old "feeding" area (above) at Central State Hospital, Ky., into the attractive "dining" room below.

Unused dining areas (left) at N.H. State Hospital are being remodeled to provide modern quarters for children (right).



At Peoria (Ill.) State Hospital a storage closet (above) becomes a chapel.

War surplus structures (upper right) are converted into a Vocational Rehabilitation Center at Arkansas State Hospital.

these offer the greatest promise, but are not in wide use yet. These materials are stainless steel, aluminum, asbestos board and Fiberglas, and are being manufactured in laminated form, with very thin sheets of the more expensive materials bonded to boards of inexpensive materials.

Today the tendency is towards allowing the sexes to mingle socially in wards and dayrooms. But the wards in most older buildings were built for one sex only, and thus have but one set of community bathing and toilet facilities. The introduction either of several private facilities or additional small community facilities is necessary to solve this problem.

### Types of Facilities Becoming Obsolete

Some types of structure which are often found in mental hospitals are becoming, or have become, obsolete as a result of changing practices, rather than as a result of obsolescence of the structures themselves.

*Personnel quarters:* These include separate homes, apartments and dormitories. There is a tendency for personnel to live in neighboring communities rather than on the hospital grounds, both from personal preference and because hospital administrators hope that a better class of personnel can be attracted from those who have their own homes and families. The traditional practice of housing all personnel on the grounds has tended to attract transient, unmarried people with no roots in the neighboring community, who can offer nothing to the hospital in the way of public relations. Thus old personnel quarters are becoming available for other purposes.

*Tuberculosis Units:* As recently as the 1930's a number of separate buildings were built for tuberculous mental patients. The declining rate of tuberculosis and more rapid treatment methods are making these units less and less used, and therefore available for new uses.

*Food Services:* The introduction of new types of food service equipment and new techniques of food preservation and storage often require the construction of new buildings, leaving the old areas unused.

*Hydrotherapy:* The general trend is decidedly in the direction of abandoning the old, cumbersome hydrotherapy rooms, the destruction of which alone is sometimes an expensive and extensive procedure. The elimination of this service, however, makes some very valuable space available.

*Farms and Farm Buildings:* More and more institutions are deciding that their farms are neither good economy nor of use in patient rehabilitation. The elimination of farming in a hospital suddenly makes available a vast amount of land and floor space, if ways can be designed to make use of it.

*Ward Dining Areas:* More and more hospitals are finding it desirable in many ways to convert from on-the-ward dining to centralized cafeteria dining. This conversion liberates a sizable amount of space on each ward for new uses.

*Clothing Rooms:* As more hospitals are changing from uniform clothing for patients to individualized clothing, there is less need than before for a central clothing area, as long as patients are given enough space for their personal possessions.

*Security Measures:* As more hospitals convert their various units to the open door policy, certain areas previously designed for security purposes make new space available. Corridors and outdoor areas, particularly, become available for new uses once the patients are given more freedom. The old special rooms for disturbed patients are also used less and less.

### Modern Requirements

On the other hand, modern trends in hospital care and new ideas in psychiatric treatment and training

procedures are creating a demand for space in existing hospitals for uses not conceived of by their original designers. In general, these trends are away from exclusive custodial care, strict economy of per diem operation, and isolation from the community, and more in the direction of rapid treatment, greater emphasis on activity programs for patients, greater provision for training of personnel, greater use of auxiliary personnel, more and better facilities for personnel, more personal luxuries for patients and personnel, better creature comforts in the way of heat and light, more administrative space, more communication equipment, more patient freedom, more contacts with the community, more mixing of the sexes, and so on. As a result, more and more pressure is being put on administrators to provide for these new space requirements.

Some of the most outstanding of these new uses, evolving from new practices, are as follows:

(1) *Activity Space:* The successful rehabilitation of patients will depend to a large degree upon the nature and extent of the supervised activities provided for them, and this will, in turn, be roughly proportional to the amount and character of the space provided for activity purposes. Activity space will include: (a) centralized activity buildings for occupational and recreational therapy, (b) on-the-ward day room space, (c) gymnasiums, (d) auditoriums, (e) swimming pools, (f) chapels, (g) theaters, (h) O.T. and recreation offices, (i) libraries, (j) canteens, (k) beauty and barber shops.

(2) *Administration:* All mental hospitals seem to operate according to Parkinson's Law, i.e., that there is a consistent growth of administrative personnel and functions, which evolves independently of hospital function. The fact remains that nearly all hospitals need more administrative space. The functions to be carried out in this space demand: (a) more private offices, (b) more record storage, (c) space for stenographic pools, dictating equipment and services, (d) more personal services for personnel in the way of lavatories, lounges, etc., and (e) modern communication equipment.

(3) *Medical Staff:* Probably no hospital has yet been built which provides enough office space for the physicians, and conversion of other types of space becomes necessary even in very new buildings. In addition to office space, there is a growing demand for: (a) medical conference rooms, and (b) professional libraries.

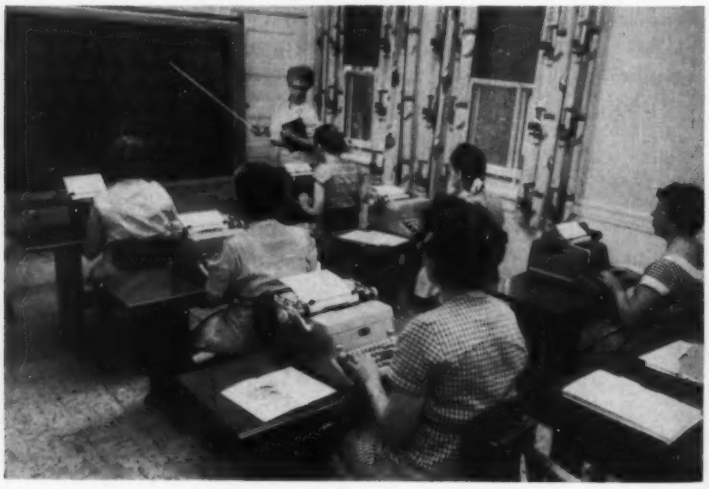
(4) *Training:* All hospitals realize the need to include training programs, and an increasing number have already instituted them for the medical staff, nursing staff, attendants, and auxiliary personnel. The space requirements for these functions include: (a) offices, (b) conference rooms, (c) libraries, (d) class rooms, (e) auditoriums, (f) quarters for student and affiliate nurses, interns and residents.

(5) *Auxiliary Personnel:* The increasing use of social workers, volunteers, psychologists, teachers, occupational therapists and recreational therapists places a demand on the administration to provide for them office, classroom and conference room facilities similar to those required by the medical staff.

(6) *Clinical Facilities:* Expanded therapeutic programs are creating the need for space for the following functions: (a) outpatient departments and follow-up clinics, (b) day hospitals, (c) physical rehabilitation, (d) vocational rehabilitation (e) dental clinics, and (f) special facilities for aged, disabled patients.

(7) *Public Facilities:* To stimulate public interest in the hospital, and to encourage interest in individual patients by members of the family, modern hospitals need: (a) more and better-equipped public waiting rooms, (b) areas where families can visit with patients, (c) outdoor areas where families can have picnics, etc. with patients, and (d) automobile parking facilities.

At New Hampshire State Hospital the old Annex, used as a nurses' home since the late 19th Century, was taken over by the Occupational Therapy Department in 1956. The pictures below and at left illustrate the new look of the old building. Unfortunately, no "before" pictures of the Annex are available.




New patients at the Center are greeted by a friendly nurse, also shown at right accompanying a patient through the grounds.

# THE NATIONAL MENTAL HEALTH CENTER

## A Free Private Psychiatric Hospital

## Denver, Colorado

IN JULY, 1958 The National Mental Health Center, Denver, Colorado, believed to be America's first private free psychiatric hospital, was opened on the grounds of the Ex-Patients' Sanatorium for Tuberculosis and Chronic Disease, and under the sponsorship of the Sanatorium's Board of Trustees. Although the hospital is Jewish-sponsored, it is non-sectarian and patients are accepted on a national basis, on purely professional criteria.

The Board of Trustees of the Sanatorium, which has existed for fifty years as a rehabilitation center, found that improvements in the quality of care for the tuberculous patient and provisions for post-acute attention in many hospitals had reduced the urgent need for beds for rehabilitation purposes. They accordingly decided that the extra buildings could most beneficially be utilized as an experimental open-type mental hospital.

### Auxiliaries Raise Funds

Initial budget estimates indicated a per diem cost of approximately $24 per patient, not including depreciation and fund raising expenses. Like the sanatorium, the National Mental Health Center is to be supported by fund-raising auxiliaries all over the country. Other than the professional staff specifically assigned to the National Mental Health Center, the patients are served by kitchen, housekeeping, maintenance and administrative employees who also serve the continuing program of the E.P.S. in tuberculosis and chronic disease. Mr. Charles K. LeVine, Executive Director of the non-medical aspects of the administration of the hospital, was formerly Administrator of Beth Israel Hospital, in Denver, and is a member of the American College of Hospital Administrators.

### Remodeling Costs Low

Remodeling began in the spring of 1958 on one of the two patient buildings on the grounds, to convert it into a 20-bed unit for ambulatory mental patients. Actual remodeling costs came to a surprisingly low $21,000 plus approximately $5,000 for furnishings.

"In considering these low remodeling costs," writes Mr. LeVine, "Two things must be kept in mind. First, we are fortunate in having certain facilities already available on the grounds. For instance, since all of our psychiatric patients are ambulatory and able to go to the dining room in the existing administration building, there was no need to include new dining facilities. Also, there is already a separate auditorium only about 150 feet east

At left Dr. Kraft and a nursing assistant pause to chat with a patient at one of the outdoor tables on the grounds. Attractive surroundings are also provided in patient rooms (above) where furniture and appointments are hotel rather than hospital syle.

of the patients' building. Second, and perhaps most important, we consider the remodeled building only a temporary makeshift to tide us over the period of the pilot study. As the program succeeds—and we are sure it will—we plan to construct an entirely new building along the lines that the A.P.A Architectural Study Project staff recommends for the ideal open hospital. Meanwhile, the present building is as safe and as efficient as we could make it within our budgetary limitations."

### Wiring and Plumbing Replaced

All wiring and all plumbing has been replaced. Each single room has a minimum of 100 square feet of floor area and larger solid slab doors have been installed in all rooms. New vinyl flooring has been laid throughout the building, and all bathroom walls have been covered with ceramic tile and plastic-coated Walltex. Walltex in various colors and patterns has also been used in all patients' rooms.

The furniture is hotel style rather than hospital type. The chairs are vinyl covered and the tops of dressers, chests and tables are finished in "Micarta."

Patient rooms and staff offices are on the first floor of the remodeled building. The lower floor contains rooms for occupational and recreational therapy.

Plans were submitted to city and state health departments and approved before re-construction began. Remodeling was kept to a minimum so that efforts and money could be concentrated on staff and program rather than on bricks and mortar.

## OUTLINE OF TREATMENT PROGRAM

By ALAN M. KRAFT, M.D., Chief Psychiatrist
The National Mental Health Center, Denver, Colo.

The basic aim of our treatment program, as originally suggested by Dr. Aaron Paley, one of our psychiatric consultants, is to direct the therapeutic efforts of this small hospital toward a particular group of patients—the so-called "borderline" group, whose illness falls somewhere between a frank psychosis and a neurotic disturbance. Without treatment, these illnesses frequently deteriorate into the more serious disorders, and the patients find their way into the already overcrowded state hospitals. If, however, the patients can be treated early, before their illness becomes irreversible, they can frequently be salvaged and returned to the community.

We do not, however, choose patients by diagnostic categories. No diagnoses, except alcoholism and certain character disorders, are considered unsuitable. When we get a referral we ask that all available clinical data on the patient be sent to us. We then review the material carefully and decide on two counts whether or not to accept the patient: 1. Do we feel that he will make significant gains toward an adequate community adjustment, given the type of treatment we have available? 2. Does the patient have a good prognosis with such treatment, and a poor prognosis without it?

We will not accept patients for domiciliary care or supervision nor, as stated above, patients such as alcoholics or those with severe character disorders, who cannot be cared for in an open hospital setting. Neither do we consider as suitable referrals those patients who

**Above: Dr. Kraft interviews a patient in his office. High staff-to-patient ratio insures each patient several hours a week of individual and group psychotherapy. Recreational therapy (right) is also part of treatment program.**

have already had many, many years of hospitalization, and who are really not able to use our type of treatment. On the other hand, several of our present patients have previously had an unsuccessful hospitalization, including shock therapies.

We are filling our twenty beds on a gradual basis, so that we can develop a program and iron out the many problems as they arise. We opened on July 1, 1958, and by the end of September had five patients. Early in October we accepted a further group of five, and by January of 1959 we expect to have all the beds filled.

### Admissions on Non-Sectarian, National Basis

Patients are accepted on a non-sectarian, national basis. We have had referrals from all over the country, and from all religious groups. In attempting to set up a satisfactory referral program, I wrote personally to five hundred psychiatrists located all over the country and all, like myself, graduates of the Menninger School of Psychiatry. Letters requesting referrals were also sent to all local psychiatrists, local social agencies and a large number of national Jewish social agencies. We shall continue, of course, to accept referrals from any source, basing acceptance purely on the professional criteria outlined above.

Thus far, we have received between eighty and one hundred referrals from two sources—medical, i.e., physicians and local agencies; and non-medical, as a result of publicity in the lay press. The professional referrals have been, by and large, excellent, but those resulting from newspaper publicity, which was primarily intended for fund-raising purposes, have been—not altogether surprisingly—rather poor.

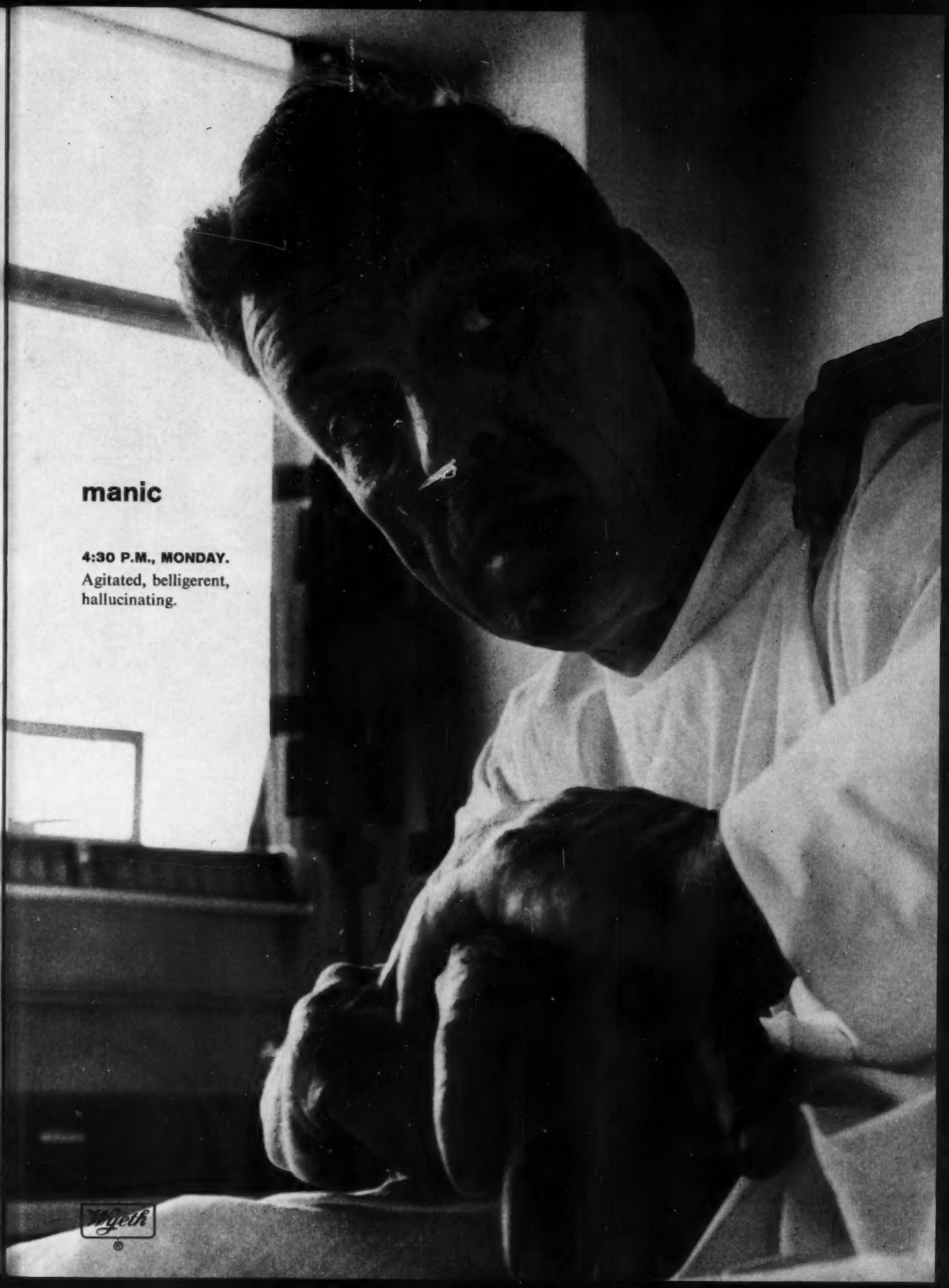
We are prepared to keep our patients for six to eighteen months if necessary. Our staff is essentially psychoanalytically oriented, and we work within this frame of reference, although none of us is a psychoanalyst. Our treatment lays heavy stress on close relationships between staff and patient. With a high staff-to-patient ratio we can lay great stress on "talking therapy" and each patient will have several hours a week of individual and group psychotherapy. We do not use any of the shock therapies, and we have no locked doors or restraints. We do, however, use the tranquilizing drugs as a treatment adjunct.

Not only do we have well equipped occupational and recreational therapy departments for our patients, but in some respects all the facilities of the city of Denver are available to these open hospital patients. Thus, outside recreational, amusement and educational facilities are being used.

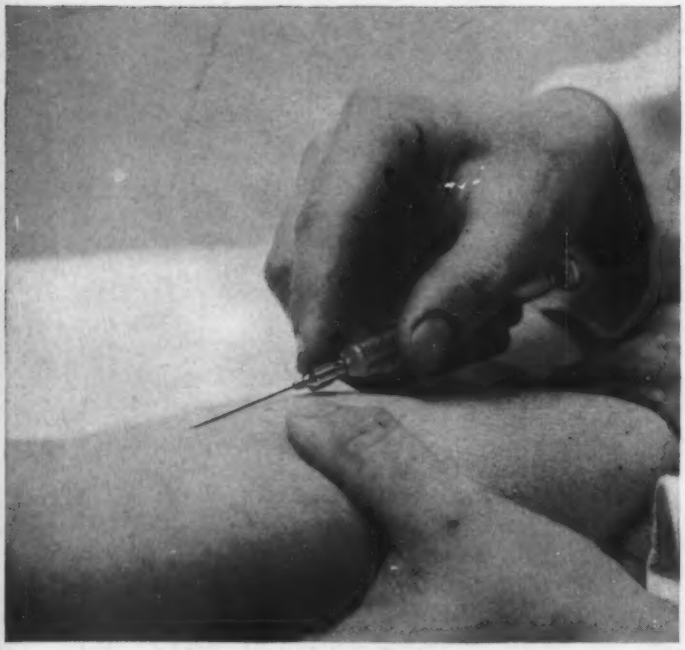
Our staff at present consists of four psychiatric nurses, three psychiatric nurse assistants and an occupational therapist. In addition we have on the staff a part-time psychologist and social worker. At the moment, I am the only psychiatrist, but another is joining our staff next January. To help me in making certain administrative and professional decisions, I asked several psychiatrists in the community to serve as an advisory board. They are Dr. Herbert Gaskill, Chairman of the Department of Psychiatry, University of Colorado Medical School; Dr. James Galvin, Medical Director of Colorado Psychopathic Hospital, and Dr. Aaron Paley. We have no direct tie-up with the University, although I am an instructor in the Department of Psychiatry.

### Venture Termed "Pilot Study"

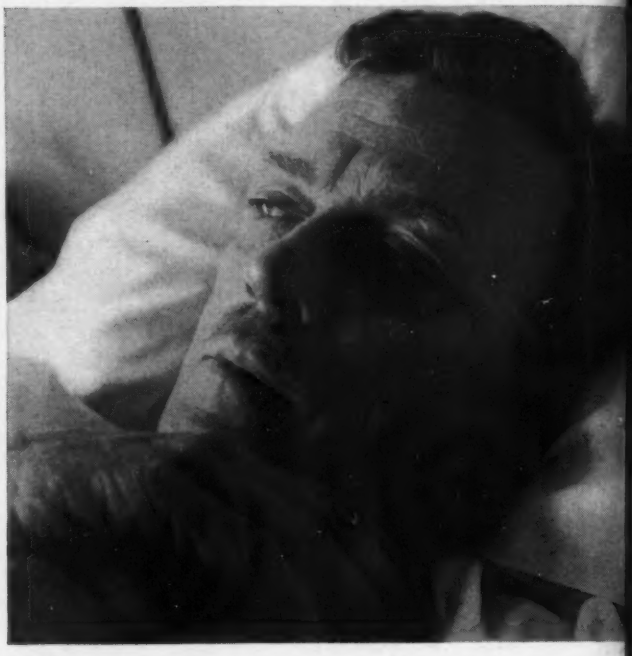
At the moment we are, for two reasons, referring to this venture as a "pilot study." First, we wish to determine whether we can successfully achieve our therapeutic goals—and we do not have too much doubt about this. Secondly, we want to discover whether the community will financially support this venture in intensive treatment aimed toward the prevention of serious illness among those productive citizens whose income doesn't permit private psychiatric hospital fees. If we succeed in these two areas—the one professional and the other financial—we shall at the end of the year drop the term "pilot study."

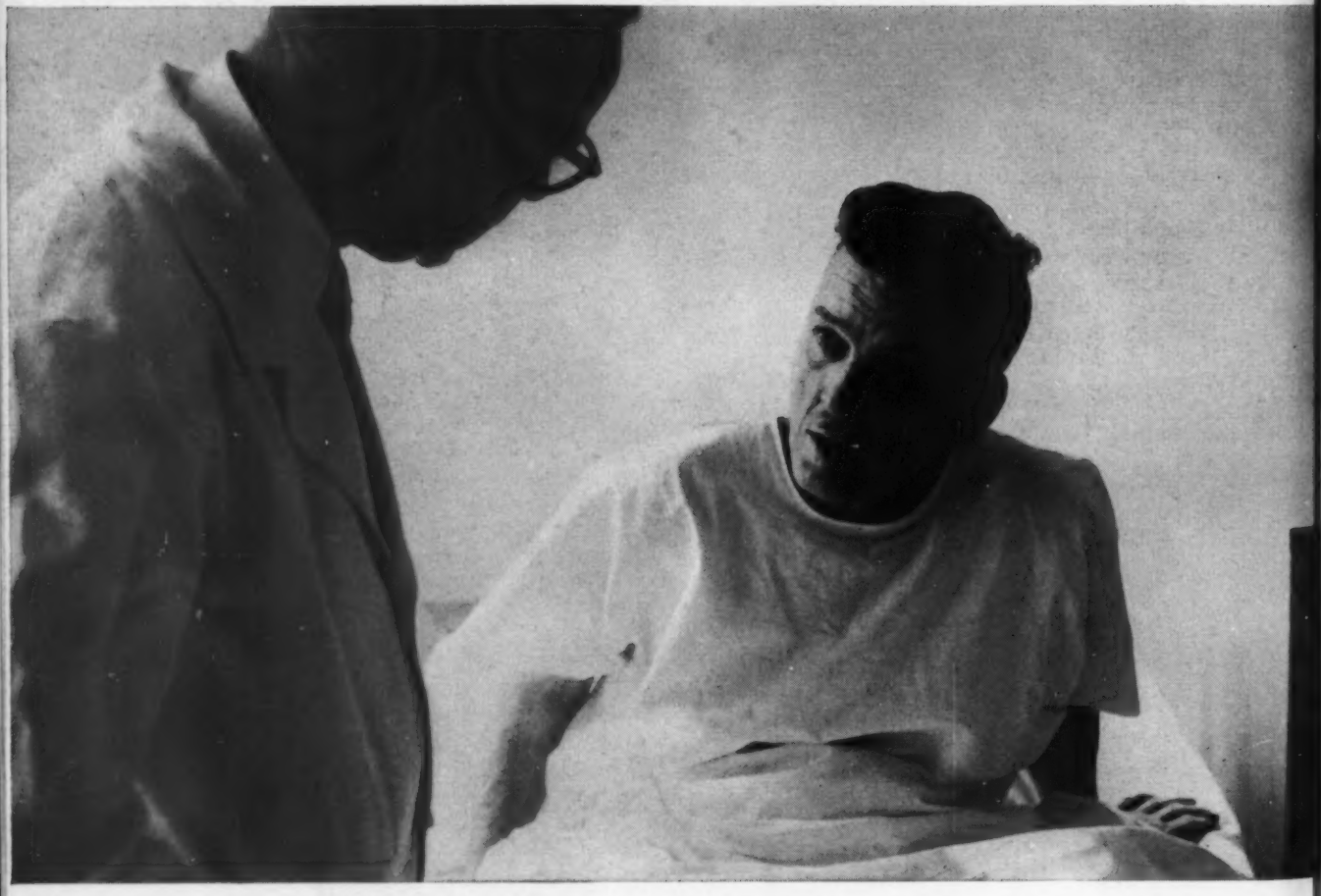

manic
4:30 P.M., MONDAY.
Agitated, belligerent, hallucinating.
Wyeth

**4:40 P.M., MONDAY.** SPARINE I.V.



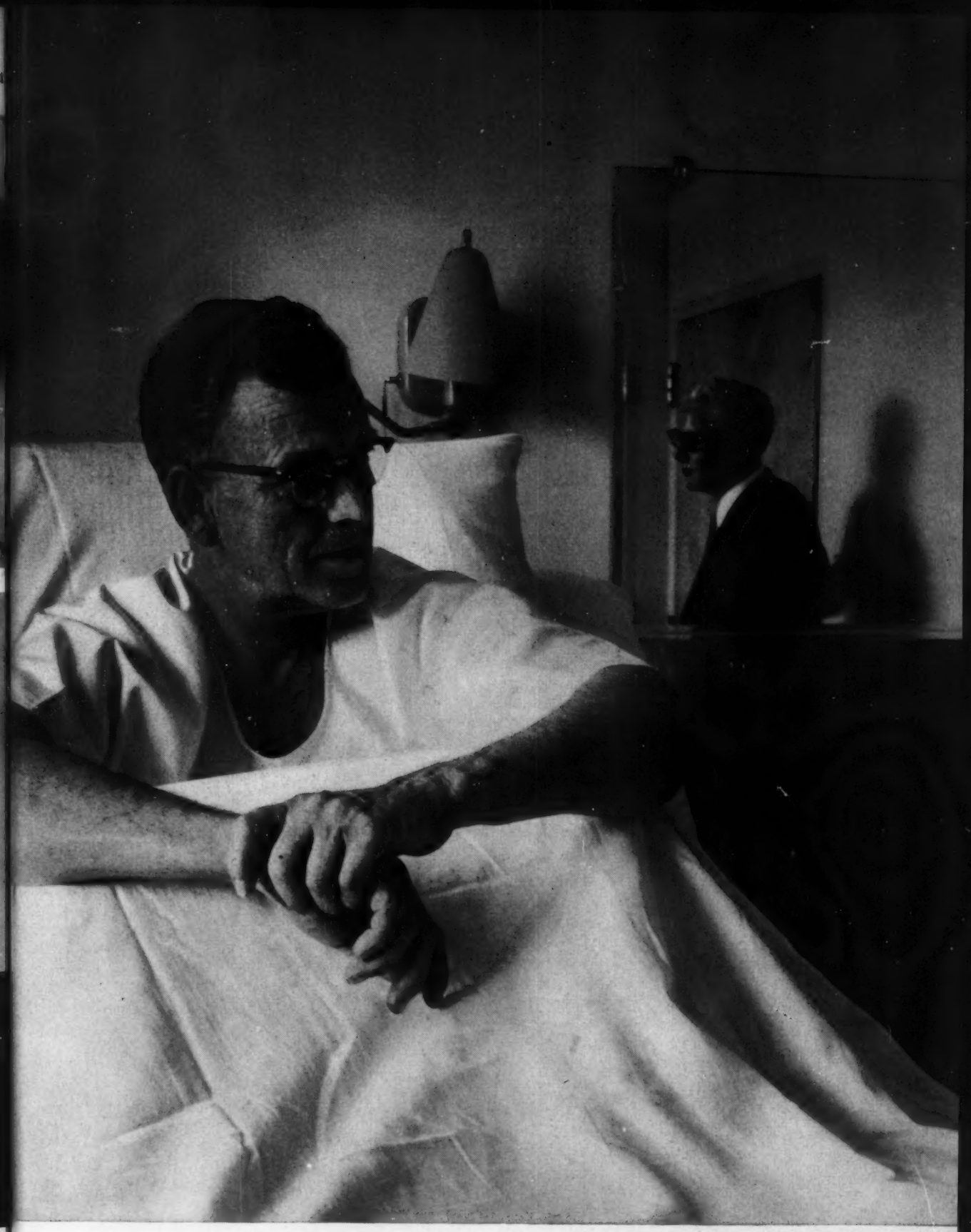
**5:00 P.M., MONDAY.** Calmer, less hostile. Responds cooperat
to questions.





Advt.

**7:30 A.M., TUESDAY.** Refreshed but some agitation remains. SPARINE I.V.



**11:10 A.M., TUESDAY.** Relaxed, nonhallucinating, alert. SPARINE orally for maintenance.

Advt.

## acute episode controlled . . . patient accessible

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## People & Places

HERE & THERE: **Dr. Mildred R. Mitchell Bateman** is now superintendent of Lakin, W.Va., State Hospital; she succeeds Dr. Simon O. Johnson . . . **Marion C. Crotty, R.N.,** principal of the school of nursing at Hudson River State Hospital, Poughkeepsie, N.Y., has been appointed assistant director of nursing services for the New York Department of Mental Hygiene . . . After 35 years at St. Elizabeths Hospital, Washington, D.C., **Dr. Theodore C. C. Fong** has become Medical Director at Madison State Hospital, Ind. . . . **Betty Jane Ely, R.N.,** has been named psychiatric nursing consultant of the Kentucky Department of Mental Health. Until her appointment, she was assistant professor of psychiatric and mental health nursing at the University of Washington School of Nursing. **Mr. Thomas J. Clark** recently became coordinator of activity therapies and volunteer services in the Ohio Division of Mental Hygiene. . . . **Dr. W. T. Miller,** senior psychologist in the Children's Service, Central State Griffin Memorial Hospital, Norman, Okla., resigned to accept the position of chief psychologist at the Child Guidance Center, Houston, Texas. . . . **Dr. Harvey J. Tompkins** was appointed chairman of the New York City Mental Health Board on November 10. . . . **Dr. Frederick Badt** was appointed Assistant Superintendent at Cleveland State Hospital, Ohio.

## Current Studies Available

*This column lists reports on investigations of interest to mental hospitals. Authors have agreed to make copies of their papers available, and requests should be sent to them directly, with 25¢ for postage and handling (unless otherwise indicated). The Editor wishes to point out that these studies have not been evaluated by the A.P.A.*

IS TRAINING FOR PSYCHIATRIC ATTENDANTS WORTHWHILE? G. Donald Niswander, M.D., George M. Haslerud, Ph.D., Earl K. Holt, M.D., Thomas M. Casey, M.A. and Jeanne M. Beatty, Arthur P. Noyes Institute for Neuropsychiatric Research, New Hampshire State Hospital, Concord, N.H.

RECEPTION AND DIAGNOSTIC CENTER, Columbus State School, Ohio; DAYTON CHILDREN'S PSYCHIATRIC HOSPITAL: LONGVIEW PSYCHOGERIATRIC CENTER, Cincinnati, Ohio. (For copies of these architectural brochures write to the Public Information Office, 1206-B State Office Building, Columbus 16, Ohio.)

PHYSICAL THERAPY, ITS PLACE AND APPLICATION IN A STATE TRAINING SCHOOL. Frederich E. Kratter, M.D., Senior Clinical Psychiatrist, Letchworth Village, Thiells, Rockland Co., N.Y. (For copies, write Miss Sarah Claytor, Scy. to Supt., Caswell Training School, Kinston, North Carolina.)

FEDERAL PROGRAMS FOR OLDER PEOPLE. (Copies available from Social Legislation Information Service, Inc., 1346 Connecticut Avenue, N.W., Washington 6, D.C.—1-5 copies, 25¢ each; 6-25 copies, 20¢ each; 26-100 copies, 15¢ each; payment should accompany order.)

FEDERAL AGENCIES FINANCING RESEARCH—Only Complete Index and Guide to Government Grants and Contracts. (Copies available from Social Legislation Information Service, Inc., 1346 Connecticut Avenue, N.W., Washington 6, D.C. at $1 each; payment must accompany order.)

PURCHASING BY THE STATES (Copies Available from the Council of State Governments, 1313 East 60th Street, Chicago 37, Illinois—$1.50 each.)

VALUE AND LIMITATIONS OF A PSYCHIATRIC DEPARTMENT IN A GENERAL HOSPITAL. N. S. Vahia, Department of Psychiatry, K. E. M. Hospital, Parel, Bombay, India. Accepted for publication in the American Journal of Psychiatry. (No other copy available.)

## QUARTERLY PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETING

1959 April 27-May 1, Municipal Auditorium, Philadelphia
1960 May 9-13, Convention Hall, Atlantic City

A.P.A. MENTAL HOSPITAL INSTITUTE

1959 Oct. 19-22, Hotel Statler, Buffalo, N.Y.
1960 Oct. 17-20, Hotel Utah, Salt Lake City
1961 Oct. 23-26, Hotel Fontenelle, Omaha, Neb.

**Other Meetings, December, 1958; January, February, 1959:**

A.P.A. DIVISIONAL MEETING, Dec. 1-3, 1958, Miami Beach, Fla.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Dec. 5-7, New York City.

ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASES, Dec. 12-13, New York City

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, Dec. 15-16, New York City

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Jan. 23-24, New York City

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS, Jan. 28, New York City.

### C.I.B. Approves More Hospitals

At its meeting on October 30, the A.P.A. Central Inspection Board officially approved the Hudson River State Hospital in New York. Also approved were the following private hospitals: Edgemont Hospital in Los Angeles, Calif., Las Encinas Hospital, Pasadena, Calif., and Harding Sanitarium, Worthington, Ohio. The addition of these hospitals brings the total of State, VA, and Provincial hospitals approved to 22. Private hospitals approved now total 12.

State hospitals added to the Conditionally Approved list by the Board at its meeting were Brooklyn, N. Y.,

Buffalo, N. Y., and Harlem Valley, N. Y. Private hospitals conditionally approved were Alexander Sanitarium, Belmont, Calif., Alhambra Sanitarium, Rosemead, Calif., Ingleside Lodge, South San Gabriel, Calif., Resthaven, Los Angeles, Calif., Twin Pines, Belmont, Calif., Vista Hill, Chula Vista, Calif., Clinica Dr. M. Julia, Hato Rey, Puerto Rico, and Puerto Rico Institute of Psychiatry (formerly Hato Tejas), Bayamon, P. R. The Conditionally Approved list now contains 46 State, VA and Provincial hospitals and 20 private hospitals.

A complete list of hospitals approved and conditionally approved prior to the October meeting was published in the June issue of MENTAL HOSPITALS.

## Southern Board Explores Mental Deficiency Problems

The Southern Regional Education Board has undertaken several projects to deal with the problems of mental retardation. An advisory panel has been formed to assist the S.R.E.B. staff in determining ways in which training and research in mental deficiency can be increased. Members of the panel represent the medical, educational, administrative and ancillary disciplines concerned with the problem. One of the panel's activities has been to plan a survey of research and training needs in the 16-state Southern region; the survey is expected to be completed early in 1959.

The Board is also sponsoring a series of small, two-day research conferences which deal with physiological, biochemical and behavioral aspects of mental retardation and mental disturbance in children.

Through an N.I.M.H. grant administered by the Board, personnel of psychiatric institutions in the Southern region can visit other institutions in the country to study better ways of doing their job. They may stay up to four weeks at a cost up to $500.

These activities are conducted by the Mental Health Program of the S.R.E.B. A separate but related unit, the Program for Teachers of Exceptional Children, is assisting the states in recruiting and training more qualified teachers of the retarded.

# HAVE YOU HEARD ?

REHABILITATION is such a major part of patient treatment that institutions across the country are going all out in an effort to achieve this goal. *The Progress,* a weekly tabloid published at **Patton (Calif.) State Hospital,** has started a classified column of Job Opportunities. It lists industrial therapy assignments open, such as "fry cooks needed for the canteen," and describes the advantages and requirements of each job in the same manner as regular newspaper Help Wanted columns.

The hospital has also instituted a system of approved patients escorting other patients who do not have ground privileges to and from special activity meetings. This Escort Service frees hospital personnel for more pressing duties.

A Night Care program has been approved and inaugurated by Dr. O. L. Gericke, the superintendent. Patients who are sufficiently improved to work in the community but who still need some hospital care and supervision will be eligible. They will return to the hospital after their day's work.

**Metropolitan State Hospital,** Norwalk, Calif., has made arrangements with the American Federation of Musicians to reinstate in good standing upon their discharge members who, as a result of lengthy hospitalization, had been dropped from the union. Those who plan to return to their profession are given, on recommendation of the hospital, a paid-up membership for three months, thus enabling them to get back on their feet and earn a living.

Two **Owatonna (Minn.) State School** boys recently received their drivers' permits. They had completed the "Driver Education" course instituted into the school curriculum in September and successfully passed the written test of the Minnesota Drivers' License Division. In addition to receiving proper instruction and meeting the requirements of the State Highway Division, the 42 boys and 27 girls enrolled in the class are taught the essentials of care and upkeep of an automobile. As far as is known, this course is the first of its kind in a state school for the mentally retarded.

STAFF EDUCATION will be greatly helped in **Kansas** by a telecommunication system linking the major mental health facilities of the state. The conference telephone service links the state hospitals and training schools with the Division of Institutional Management, Menninger Foundation and the Topeka VA Hospital. Its purpose is educational and administrative and it is believed that it will prove invaluable to the Kansas mental health service.

The Audio-Digest Foundation, a non-profit subsidiary of the California Medical Association, has just released its second hour-long tape recording of a psychiatric meeting this year. (The first one in the field of psychiatry was made at the A.P.A. Annual Meeting in San Francisco.) The Tenth Mental Hospital Institute provided the background for this new recording—highlights of important papers and personal interviews. These tapes will be distributed by Smith Kline and French Laboratories Hospital Service representatives to all state and VA hospitals, mental health commissioners and central offices and District Branches of A.P.A.

The professional staff at **Topeka (Kansas) State Hospital,** began holding monthly meetings last September to present scientific papers to each other for discussion and criticism. Purposes of the meetings are twofold: 1) to encourage writing scientific papers for publication; and 2) to increase interdepartmental and inter-sectional communication of scientific ideas. Each department will present a paper based on work completed or in process.

**Columbus (Ohio) State Hospital** is the first state hospital in Ohio to receive approval to give a three year psychiatric residency training program.

In September, some 20 Public Health officers from various counties and a number of others interested in follow-up care met at **Eastern State Hospital (Wash.)** to discuss problems of planning and personnel.

CONSTRUCTION of a new VA hospital in Brecksville, near Cleveland, Ohio is planned by the **Veterans Administration.** Bids are now being accepted for construction of a 1,000 bed neuropsychiatric hospital which will cost an estimated $20 million or more.

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- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
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*Intramuscular:* 15 mg. average single dose
Dosage range 5-15 mg.
If subsequent parenteral dose is needed, one-half the original dose will usually suffice
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*Parenteral solution* – 1 cc. ampuls (20mg./cc.), 1 cc. multiple dose vials (20 mg./cc.)
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VOLUME IX

## RESEARCH AND TRAINING



## REVIEWS:



### *Book Reviews:*



### *Film Reviews:*



## VOLUNTEERS



## MISCELLANEOUS



## AUTHORS & SUBJECTS

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*References:* 1. Barsa, J. A.: Am. J. Psychiat. 115:79, July 1958. 2. Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Connecticut M. J. 21:1047, Dec. 1957. 3. Hollister, L. E., Elkins, H., Hiler, E. G. and St. Pierre, R.: Ann. New York Acad. Sc. 67:789, May 9, 1957. 4. Pennington, V. M.: Am. J. Psychiat. 114:257, Sept. 1957. 5. Tucker, K. and Wilensky, H.: Am. J. Psychiat. 113:698, Feb. 1957.

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